CCME

2018 External Quality Review

BLUECHOICE HEALTHPLAN

Submitted: June 14, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by BlueChoice HealthPlan (BlueChoice) since the 2017 Annual Review.

The goals of the review are to:

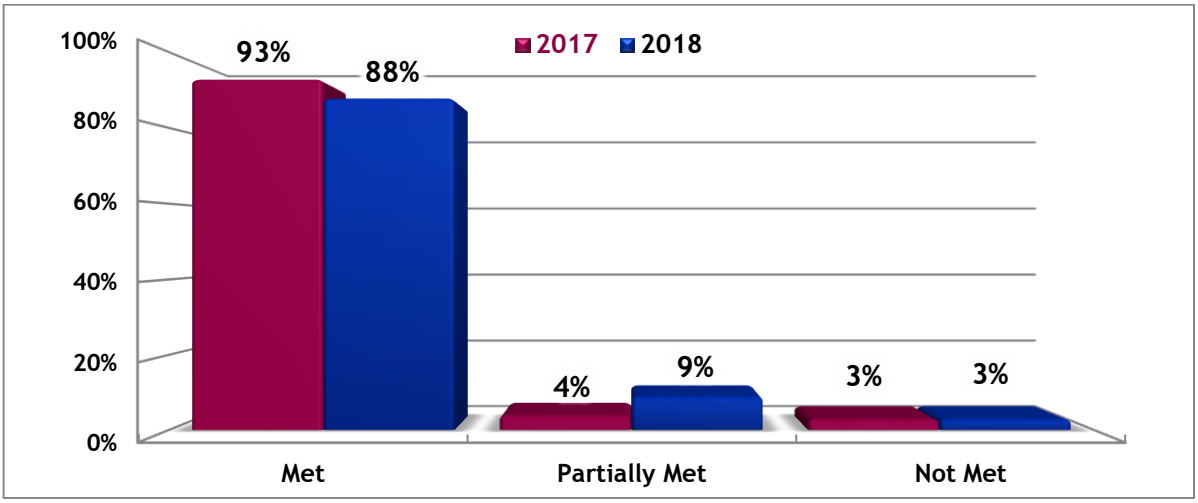
- Determine if BlueChoice is in compliance with service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2017 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The process CCME used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPSs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2018 annual EQR review shows that BlueChoice achieved a “Met” score for 88% of the standards reviewed. Nine percent of the standards were scored as “Partially Met,” and three percent of the standards scored as “Not Met.” The chart that follows provides a comparison of BlueChoice’s current review results to the 2017 review results.

Figure 1: Annual EQR Comparative Results



A summary overview for each area measured is included in this Executive Summary. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items, and recommendations can be found in each respective section of this report.

Administration:

BlueChoice has filled all key positions with qualified staff, and the plan defines all education and experience requirements in policy and job descriptions.

Policies are well-organized, reviewed annually, and revised as needed. CCME noted an inconsistency in the frequency of policy review in the Quality Improvement (QI) Program Description. The Medicaid Business Unit policy titled "Policy and Procedure Reviews" does not include information specific to South Carolina.

Information System Capabilities Assessment (ISCA) documentation provides an overview of systems, processes, and polices to service the *SCDHHS Contract*. The disaster recovery test documentation demonstrates an emphasis on system resilience and recoverability by acknowledging areas for improvement. The policies and procedures appear to be maintained regularly and updated to encompass current security concerns and compliance requirements.

BlueChoice's *Compliance Plan* along with policies and Anthem's *Special Investigations Unit Antifraud Plan* define processes to guard against fraud, waste, and abuse (FWA). Standards of business conduct for employees are outlined in the *Our Values* document.

CCME noted discrepancies in the Compliance Committee's membership in the *Compliance Committee Charter*, QI Program Description, and *Committee Membership List*. This is a

deficiency identified during the previous EQR. Also, discrepancies are noted in documentation the frequency of Compliance Committee meetings, and the documentation does not match the frequency reported by staff during onsite discussion.

Provider Services:

The BlueChoice *Credentialing Program Description* and several policies address the credentialing processes. The information is comprehensive; however, the *Terminated for Cause List* is not mentioned as a query used for credentialing, recredentialing, or ongoing monitoring. In addition, the Social Security Death Master File (SSDMF) is not listed as a query used for ongoing monitoring. The credentialing/recredentialing file review shows appropriate documentation except for the SSDMF and *Terminated for Cause List* queries. Proof of the SSDMF queries is inconsistent due to issues with access to the query site. The process was implemented in February 2018.

A few additional issues are discussed in the report related to provider appointment accessibility not being assessed at the provider level, outdated information on the website for preventive and clinical practice guidelines, and documents for medical record review not containing minimum requirements.

Results of the CCME-conducted telephonic Provider Access Study revealed a statistically significant increase when compared to the previous year. The successful answer rate is 69% for the current year and 45% for the previous year.

Member Services:

The packet of information sent to new members includes the *Member Handbook*, documentation of any changes to the *Member Handbook*, a Member ID Card, an introductory letter, and information to help members understand the health plan and benefits. CCME identified a few issues with the content of the *Member Handbook* and provides suggestions to correct these issues. Members are informed of rights to which they are entitled at the time of enrollment via the *Member Handbook* and annually in the *Member Newsletter*.

The Customer Care Center (CCC) is staffed as required by the *SCDHHS Contract*. After normal business hours, callers receive instructions on what to do in an emergency, an option to speak with a nurse/clinician, and an option to leave a message. The Customer Care Center located in Savannah, GA will soon transfer all functions to Denver, CO and Indianapolis, IN. CCME's review of call metrics for the CCC confirm compliance with contractual requirements.

CCME noted issues in documentation of grievance processes including the grievance acknowledgement process and grievance resolution timeframes. CCME noted minor issues

in the grievance files. Also, CCME found instances where grievances should have been referred for further investigation due to potential quality of care issues.

Sample sizes for the *Member Satisfaction Survey* are adequate and meet the NCQA minimum sample size and number of valid surveys, but response rates are below the NCQA target of 40%. Actual response rates are 27.59% (Adult) and 25.65% (Child). CCME provided recommendations to help increase response rates.

One standard in the Member Services section of the review is scored as "Not Met" due to an uncorrected deficiency identified during the previous EQR.

Quality Improvement:

CCME's Quality Improvement sections included a review of the QI program description, program evaluation, committee minutes, policies, performance measures and performance improvement project validation.

BlueChoice provided the *2017 Medicaid Quality Management Program Description* as evidence that the program is designed to provide the structure and key processes for ongoing improvements of care and services available to members and providers.

BlueChoice uses Inovalon, a certified software organization, to calculate HEDIS rates. Comparison between the previous and current years revealed strong increases in MMR, Flu vaccinations, Lead Screening in Children, Adolescent Well Care visits, and additional measures. The key measures that decreased are Statin Adherence and Cardiovascular Monitoring for People With Cardiovascular Disease, and Schizophrenia.

CCME validated two projects using the *CMS Protocol for Validation of Performance Improvement Projects*. One project evaluated is clinical, titled "Childhood Immunizations Combo 3 and Lead Screening," and one is non-clinical, titled "Access and Availability of Care." The Access and Availability of Care scored 96% last year and 83% this year. The *Combo 3 and Lead Screenings Performance Improvement Project* (PIP) scored 95% last year and 83% this year. Last year, the *Access and Availability of Care PIP* had an issue with the baseline and benchmark rate definitions. The *Childhood Immunization PIP* had issues last year with baseline and benchmark rate definitions as well as the Combo 3 improvement. Those issues remain present in the most recently submitted documentation. During the onsite visit, BlueChoice stated that the *Combo 3 and Lead Screening PIP* is in the process of being closed. The PIP document does not contain a statement about it being closed or retired; therefore, it is validated as an active project. For both PIPs, there is a lack of documentation on interventions.

Utilization Management:

CCME's assessment of the Utilization Management (UM) section includes reviews of program descriptions, program evaluations, policies, committee minutes, corresponding reports, and appeal, approval, denial, and case management files.

BlueChoice contracts with Amerigroup Partnership Plan for UM services in South Carolina. The *Utilization Management Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health (BH). UM policies and procedures define how utilization management, medical necessity determinations, appeals, and case management services are operationalized to service members. The Amerigroup Medical Director, Imtiaz Khan MD, provides oversight of UM activities.

CCME identified inconsistencies in documentation of the receiving area for mailed member appeal requests. CCME could neither identify how BlueChoice conducts an initial screening of each enrollee's needs within 90 days of enrollment, nor could CCME identify a Transition Coordinator. CCME provides recommendations to address these issues.

Delegation:

BlueChoice delegates credentialing and recredentialing functions to several entities. Various medical review services, federal external reviews, and Special Investigations Unit (SIU) reviews are delegated to Anthem. Pharmacy services are delegated to Express Scripts, Inc. Delegation agreements are in place with all delegated entities and annual oversight is conducted according to guidelines. One standard is scored as "Partially Met" because the Social Security Death Master File (SSDMF) is not listed as a query item in Policy MCD-10, and the *Terminated for Cause List* is not addressed as a required query in the delegation oversight tool, *Credentialing Requirements for Vendor* document, and the respective policy.

State Mandated Services:

For the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, BlueChoice encourages providers to follow recommendations from the Centers for Disease Control and the American Academy of Pediatrics. Network providers are informed of the EPSDT program and immunizations schedule via the *Provider Manual*, *Provider Bulletins*, and other communications. The plan also provides quarterly Gaps in Care reports to providers. BlueChoice assesses provider compliance with the provision of EPSDT services and required immunizations through random medical record reviews.

BlueChoice provides all core benefits required by the *SCDHHS Contract*.

CCME identified deficiencies not addressed from the previous EQR, resulting in one score of "Not Met" for the State Mandated Services section of this review.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2017 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	31	1	1	0	0	33
2018	38	0	1	0	0	39
Provider Services						
2017	69	5	1	0	0	75
2018	66	10	2	0	0	78
Member Services						
2017	35	1	1	0	0	37
2018	28	4	1	0	0	33
Quality Improvement						
2017	15	0	0	0	0	15
2018	13	2	0	0	0	15
Utilization						
2017	35	2	1	0	0	38
2018	42	2	1	0	0	45
Delegation						
2017	2	0	0	0	0	2
2018	1	1	0	0	0	2
State Mandated Services						
2017	3	0	1	0	0	4
2018	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for the EQR is based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects (PIPs).

On March 19, 2018, CCME notified BlueChoice that the Annual EQR was being initiated (see Attachment 1). This notification includes a list of materials required for a desk review and an invitation for a teleconference designed to provide BlueChoice with an opportunity to ask questions regarding the EQR process and the requested desk materials.

The review consists of two segments. The first segment is a desk review of materials and documents received from BlueChoice on April 2, 2018 and reviewed in the offices of CCME (see Attachment 1). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement (QI) and Medical Management Programs. Also included in the desk review is a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment is an onsite review conducted on May 17, 2018 and May 18, 2018 at the BlueChoice office located in Columbia, SC. The onsite visit focuses on areas not covered in the desk review and items needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities include an entrance conference, interviews with administration and staff, and an exit conference. All interested parties are invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following sections and are based on the regulations set forth in *Title 42 of the Code of Federal Regulations (CFR), part 438*, and the contract requirements between BlueChoice and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. CCME identifies areas of review as meeting a standard - “Met,” acceptable but needing improvement - “Partially Met,” failing a standard - “Not Met,” “Not Applicable,” or “Not Evaluated,” on the tabular spreadsheet (Attachment 4).

A. Administration

The Administration section of The Carolinas Center for Medical Excellence (CCME) review of BlueChoice HealthPlan of South Carolina (BlueChoice) focuses on health plan policies, staffing, information systems, compliance, and confidentiality practices. BlueChoice

contracts with Amerigroup Partnership Plan, LLC (a wholly-owned subsidiary of Anthem Inc.) for administrative services.

Policies are well-organized, reviewed annually, and revised as needed. Onsite discussion confirms annual policy review for all departments, but CCME noted inconsistencies in the frequency of policy review in the *Quality Improvement (QI) Program Description*. The Medicaid Business Unit policy titled "Policy and Procedure Reviews" does not include information specific to South Carolina.

Tim Vaughn is the President and Chief Operating Officer (COO) of BlueChoice. Other key positions required by the SCDHHS Contract are filled by Jennifer Thorne, Chief Financial Officer (CFO); Amy Bennett, Contract Account Manager and Interagency Liaison; Damian Bridges, Quality Director; Victoria McNeil Brock, Utilization Management (UM) Director; Nicholas Von Gersdorff, Encounters Manager; Christopher Kearney; Claims Manager; Rod Johnson, Compliance Officer; Scott Timmons, Provider Service Manager; Donna Williams, Member Service Manager; Melanie Joseph, Legal; Jonathan Jones, Pharmacy Director; and Imtiaz Khan, Medical Director. Dr. Khan is supported by an additional Medical Director, Dr. Kim Cooley. Dr. Tracey Smithey, a board-certified psychiatrist, serves as Medical Director for Behavioral Health.

CCME's review of Information System Capabilities Assessment (ISCA) documentation finds that business continuity measures are in place for the systems servicing BlueChoice. A recent disaster recovery (DR) test was successful in restoring claims systems and indicates that Anthem is working to reduce recovery times to meet its recovery time objectives. Claims data confirms 90% of claims are paid within 14 days of receipt, 98% are paid within 30 days of receipt, and 99% within 90 days of receipt. A corporate review team conducts random claims audits to verify accuracy and that internal and contractual requirements are met.

BlueChoice's *Compliance Plan* along with policies and Anthem's *Special Investigations Unit Antifraud Plan* define processes to guard against fraud, waste, and abuse (FWA). Onsite discussion revealed the Compliance Plan was revised recently and is expected to receive approval from the Compliance Committee in June 2018. The *Anthem Special Investigations Unit Antifraud Plan* was last updated in September 2017. Standards of business conduct for employees are outlined in the *Our Values* document.

The Compliance Committee oversees the development, implementation, and effectiveness of the *Compliance Plan*. Discrepancies are noted in the committee membership when comparing the *Compliance Committee Charter*, the QI Program Description, and the *Committee Membership List*. This is a deficiency identified during the previous EQR. A discussion during the onsite visit confirmed the Compliance Committee meets quarterly; however, the *Compliance Committee Charter* indicates the

committee meets monthly (but no less than 10 times yearly), and the QI Program Description states the committee meets monthly (but no less than 4 times yearly).

As noted in *Figure 2, Administration Findings*, BlueChoice received "Met" scores for 97% of the standards in the Administration review. One standard is scored as "Not Met" due to an uncorrected issue identified during the previous EQR.

Figure 2: Administration Findings

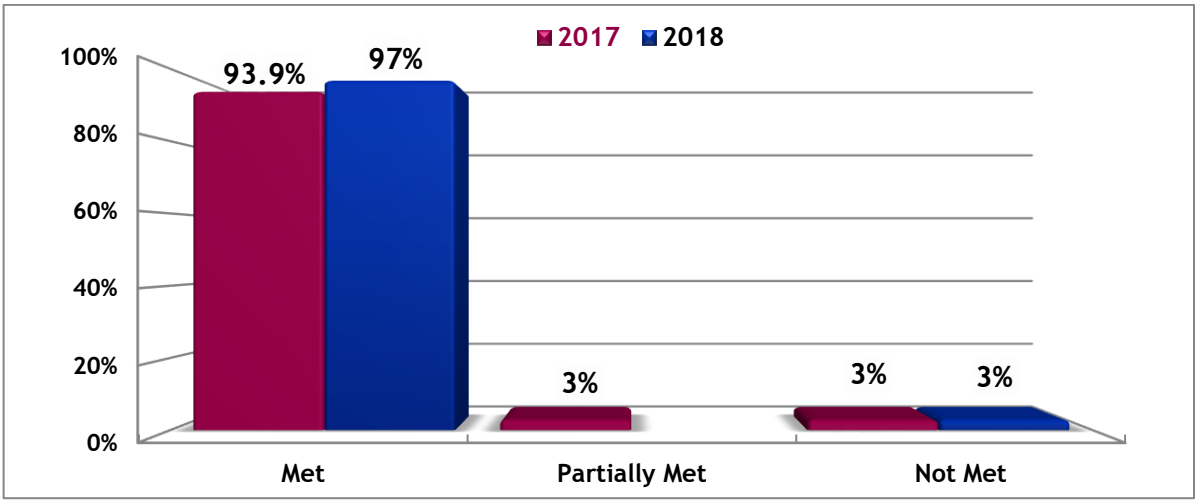


Table 2: Administration Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Organizational Chart / Staffing	The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: Pharmacy Director	Not Met	Met
Compliance / Program Integrity	The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The Compliance Department has an *Ethical Decision-Making Guide* to assist employees in decision making. Placards containing the information are distributed to each staff member for quick reference.
- Workforce security overview documentation is up-to-date and disaster recovery resources are consolidated into Excel workbooks that detail the overall recovery process.

Weaknesses

- Onsite discussion confirmed all policies are reviewed annually. Page 33 of the QI Program Description states Quality Management Department policies are reviewed, at a minimum, biennially. Also, the Medicaid Business Unit policy titled, "Policy and Procedure Reviews" states, "By default all P&Ps are reviewed biennially (every 2 years); however, this may be changed to an annual review cycle depending on state contract, accreditation, and department of ownership's purview." This policy includes state-specific exceptions on pages seven and eight; however, the policy does not include information specific to South Carolina.
- The organizational chart is difficult to understand. For example, for positions not identified as key positions it is unclear if staff members are BlueChoice or Amerigroup employees. Employee locations are also unclear.
- Disaster recovery tests reveal areas that can be improved.
- Discrepancies are noted in the Compliance Committee membership when comparing the *Compliance Committee Charter*, the QI Program Description, and the *Committee Membership List* for the Medicaid Compliance Committee. This is a deficiency identified during the previous EQR.
- BlueChoice staff revealed, and committee minutes confirm, that the Compliance Committee meets quarterly. However, the *Medicaid Compliance Committee Charter* indicates the committee meets monthly (but no less than 10 times yearly), and the QI Program Description states the committee meets monthly (but no less than 4 times yearly).
- The QI Program Description, page 35, states all employees undergo Health Insurance Portability and Accountability Act (HIPAA) training within 60 days of the date of hire. Onsite discussion revealed new employees receive HIPAA training on the first day of employment, prior to receiving a computer, ID badge, etc.

Quality Improvement Plans

- Revise Compliance Committee membership documentation for consistency across all documents.

- Correct the frequency of Compliance Committee meetings in the *BlueChoice HealthPlan Medicaid Compliance Committee Charter* and QI Program Description.

Recommendations

- Revise the QI Program Description to state policies are reviewed at least annually and add a South Carolina exception to the "Policy and Procedure Reviews" policy indicating policies are reviewed annually.
- Revise the organizational chart to indicate whether each staff member is a BlueChoice or Amerigroup employee and to provide staff locations.
- Focus on verifying systems and administrative tools function properly and are current prior to disaster recovery testing. CCME recommends paying special attention to information technology (IT) maintenance to reduce disaster recovery issues.
- Update the QI Program Description, page 35, to state new employees receive HIPAA/confidentiality training prior to being granted access to Protected Health Information (PHI).

B. Provider Services

CCME conducted a review of all policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines for Provider Services.

The BlueChoice Credentialing Committee is chaired by Dr. Lloyd Kapp, Medical Director, and he has the responsibility for all credentialing and recredentialing activities including approval of policies and procedures. Additional committee members include the Vice President of Medical Affairs and nine network providers with specialties including internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, and dental. Only network providers on the committee have voting privileges and a quorum is met with three network providers. A review of committee minutes showed good participation by voting members, and a quorum was met at each meeting reviewed.

Credentialing approval activities related to behavioral health are the responsibility of the Companion Benefit Alternatives (CBA) Credentialing Committee. The CBA Credentialing committee has a total of 10 voting members with three of the committee members participating as external providers.

The *Credentialing Program Description* and several policies address the BlueChoice credentialing processes. The information is comprehensive; however, the *Terminated for Cause List* is not mentioned as a query responsibility for credentialing, recredentialing, or ongoing monitoring. In addition, the *Social Security Death Master File* (SSDMF) is not listed as a query responsibility for ongoing monitoring. The credentialing/recredentialing

file review shows appropriate documentation except for the SSDMF and *Terminated for Cause List* queries. Proof of the SSDMF is inconsistent due to issues with access to the query site. The process was implemented in February 2018.

A few additional issues are discussed in the Weaknesses section related to provider appointment accessibility not being assessed at the provider level, outdated information on the website for preventive and clinical practice guidelines, and documents for medical record review not containing minimum requirements.

Provider Access and Availability Study

As part of the annual EQR process for BlueChoice, CCME conducted a Telephonic Provider Access Study that focused on primary care providers (PCPs). BlueChoice provided a list of current providers to CCME, from which CCME identified a population of 3,060 PCPs. CCME selected a random sample of 309 PCPs from this population and attempted to contact these providers to ask a series of questions regarding access that members have with their contracted providers.

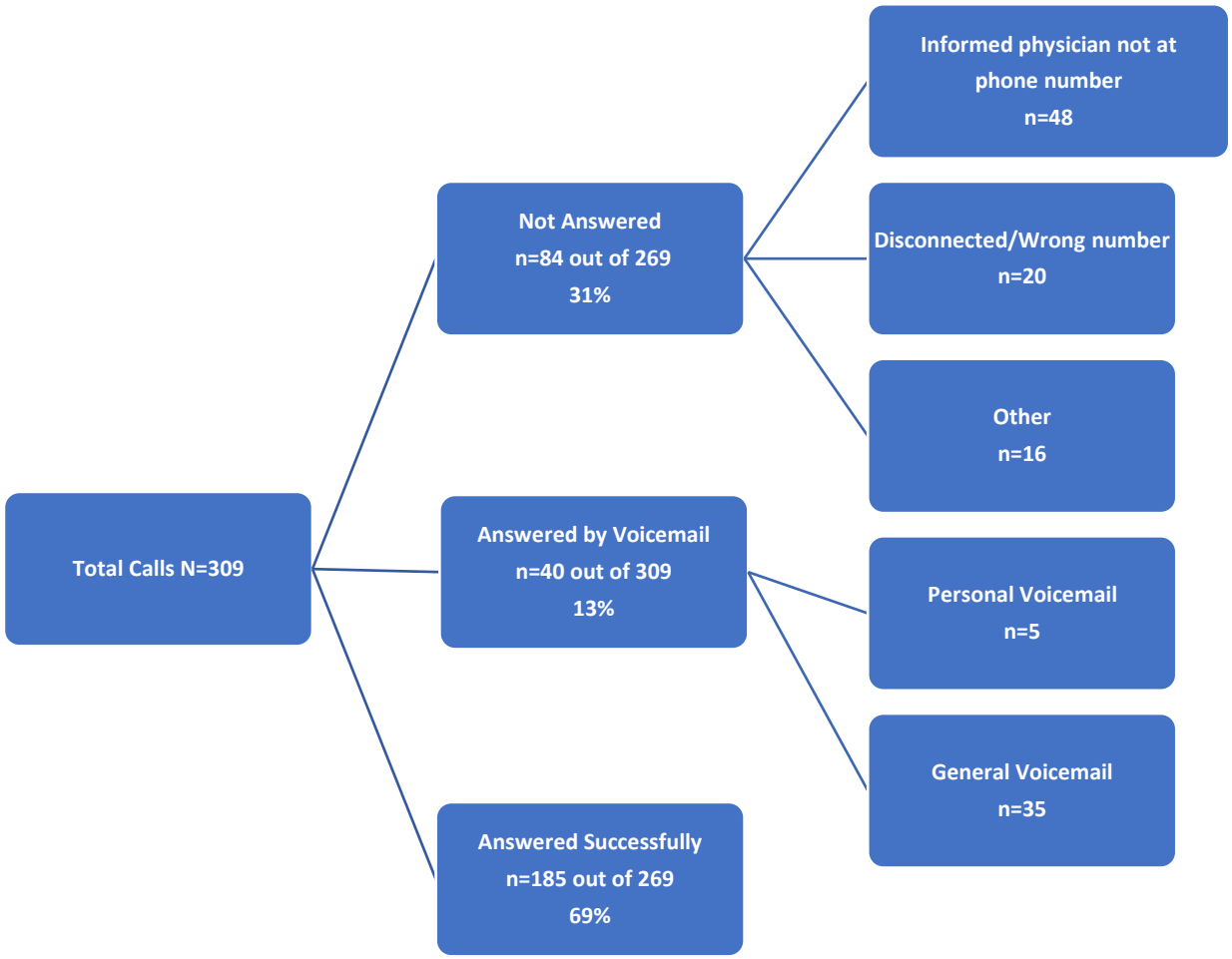
Table 3: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact P-value
2017 Review	311	45%	<.001
2018 Review	309*	69%	

*denominator for answer rate was 269 to account for voicemail answering services for 40 calls

In reference to the results of the Telephonic Provider Access Study conducted by CCME, calls were successfully answered 69% of the time (185 out of 269) when omitting 40 calls answered by personal or general voicemail messaging services (see Figure 3 below).

Figure 3: Telephonic Provider Access Study Results



When compared to the prior year results of 45%, the increase in successful answer rate is statistically significant ($p<.001$).

For calls not answered successfully (n=84 calls), 48 (57%) were unsuccessful because the provider was not at that office or phone number listed. One hundred and fifty-seven (85%) of the providers indicated that they accept BlueChoice, and two (1%) indicated that this occurred only under certain conditions. One-hundred and thirty-six out of 156 (87%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 42 (30%) of the 138 providers that responded to the item indicated that an application or prescreen is necessary. Out of 39, 18 (46%) indicated that an application must be completed, whereas eight (21%) require a

review of medical records/immunizations before accepting a new patient, and 13 (33%) require both. When the office was asked about the next available routine appointment, 99 out of 139 (71%) met contact requirements.

Figure 4, Provider Services Findings, shows that 85% of the standards in Provider Services received a "Met" score. *Table 4, Provider Services Comparative Data*, highlights standards that showed a change in score from 2017 to 2018.

Figure 4: Provider Services Findings

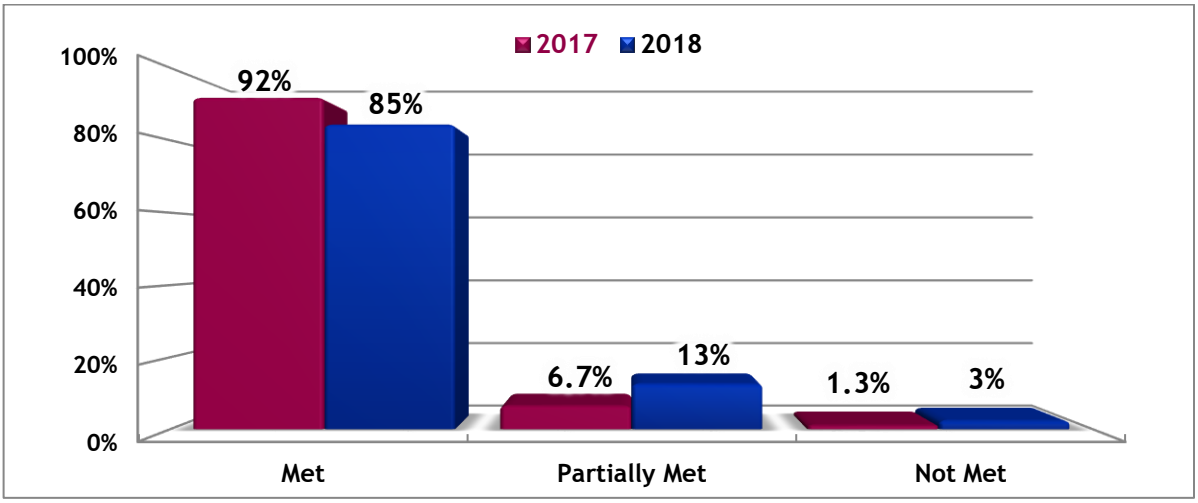


Table 4: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Primary and Secondary Preventive Health Guidelines	The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Partially Met
Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Partially Met
Practitioner Medical Records	Standards for acceptable documentation in member medical records are consistent with contract requirements.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The Telephonic Provider Access Study successful call rate increased significantly from last year when omitting voicemail-answered calls. Onsite discussion confirmed special efforts were made by the provider representatives to update provider information during onsite visits.

Weaknesses

- The *Medicaid Credentialing Program Plan* does not mention querying the *Terminated for Cause List* at credentialing and recredentialing for providers and facilities.
- Policies MCD-04, Initial Credentialing, and MCD-05, Recredentialing, do not address querying the *Terminated for Cause List*.
- The credentialing and recredentialing files reviewed did not show evidence of query of the *Terminated for Cause List*.
- CCME's review of credentialing and recredentialing files show inconsistency in evidence of queries of the SSDMF. BlueChoice indicated at the onsite that it began applying to have access to the SSDMF query site in April 2017 and had problems with access that were out of their control. BlueChoice implemented a process in February 2018.

- Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing, does not address querying the *Terminated for Cause List* and the credentialing/recredentialing files do not reflect evidence of the query.
- Multiple policies and the *Credentialing Program Description* address processes related to ongoing monitoring; however, the information is fragmented and difficult to understand. The SSDMF and the *Terminated for Cause List* are not listed as a query responsibility in any policy or in the *Credentialing Program Description* related to ongoing monitoring.
- BlueChoice does not assess appointment compliance at the provider level.
- The *BlueChoice HealthPlan Medicaid Practitioner Access Analysis January 1, 2017 to December 31, 2017* report defines the access indicator for routine care as "within two weeks (10 days)"; however, Policy PN001, Access/Availability Standards for CBA Network, defines routine office visits as "within 10 working days."
- The following are issues related to preventive and clinical practice guidelines:
  - A preventive health guidelines brochure was provided in the desk materials and is loaded to the website. The brochure appears outdated with a date of May 2016.
  - The behavioral health clinical practice guidelines loaded to the website are outdated with references such as "Reviewed/Approved 12/2013."
  - Behavioral health clinical practice guidelines are not addressed in the *Provider Manual*.
  - The Member/Eligibility section of the Provider Website has a link to behavioral health guidelines, but it is not located where the other clinical practice guidelines are listed.
  - The website has a clinical practice guidelines matrix that appears to be current, but there are other guidelines listed on the same web page with outdated references such as "reviewed/approved 5/2012, reapproved 12/2013." It is difficult to understand if these are a part of the adopted guidelines or why the dates are not current.
- Policies MCD-12, Medical Record Review for Documentation Standards, and SC_QMXX_105, Medical Record Review, both address medical record review and BlueChoice provided two different Medical Record Audit Tools. Both tools are missing one or more minimum requirements in the *SCDHHS Policy and Procedure Guide, Section 15.8*.

Quality Improvement Plans

- Update the *Credentialing Program Description* and Policies MCD-04 and MCD-05 to address querying the *Terminated for Cause List* at credentialing and recredentialing.

- Ensure credentialing and recredentialing files contain proof of query of the *Terminated for Cause List*.
- Ensure credentialing and recredentialing files contain evidence of query of the SSDMF.
- Update Policy MCD-06, Health Care Delivery Organizations – Credentialing/ Recredentialing, to reflect the need to query the *Terminated for Cause List*. Ensure credentialing/recredentialing files contain proof of query of the *Terminated for Cause List*.
- Ensure the *Credentialing Program Description* and appropriate policies address the need to query the *Terminated for Cause List* and the SSDMF for ongoing monitoring.
- Define and implement a process to evaluate appointment access at the provider level to ensure provider compliance to appointment standards.
- Ensure consistency between documents regarding the behavioral health appointment access standard for routine care.
- Ensure the preventive health guidelines brochure reflects current adopted preventive guidelines.
- Update the website to reflect current behavioral health preventive and clinical practice guidelines.
- Remove outdated clinical practice guidelines from the website. Address behavioral health guidelines in the *Provider Manual* and on the Medicaid website.
- Ensure the medical record review policies address the current review process and the review tools address all contract requirements.

Recommendations

- Consider consolidating policies to clarify the ongoing monitoring process.
- Consider consolidating policies to clarify the medical record review process.

C. Member Services

The CCME review of Member Services includes member rights and responsibilities, member disenrollment, grievances, the member satisfaction survey, and member education related to the Managed Care Organization (MCO) program, preventive health, and chronic disease management.

Documentation of member rights is consistent in policy, the *Member Handbook*, the *Provider Manual*, and the BlueChoice website, and includes all rights mandated by the *SCDHHS Contract* and by Federal Regulation. In addition, members are informed annually of rights to which they are entitled via the *Member Newsletter*.

Upon enrollment, members are sent a packet of information including the *Member Handbook*, documentation of any changes to the *Member Handbook*, a *Member ID Card*, an introductory letter, and additional information to help them understand the health plan and member benefits. BlueChoice maintains a log of changes to the *Member Handbook* on its website. The *Member Handbook* contains most required information; however, CCME identified issues with the content of the *Member Handbook*. These issues are addressed in the Weaknesses section of this report.

BlueChoice's Customer Care Center (CCC) is staffed from 8:00 AM to 6:00 PM, Monday through Friday, excluding state holidays. CCME suggests a minor revision to Policy SC_CSPC_002, Customer Service, clarifying the business hours for the CCC. The toll-free CCC telephone number, available around-the-clock, gives emergency instructions and options to speak with a nurse/clinician or to leave a message. Messages are returned the next business day. The CCC is currently located in Savannah, Georgia, but functions are scheduled for transfer to Denver, Colorado and Indianapolis, Indiana. CCME's review of call metrics for the CCC confirms compliance with contractual requirements.

The *Member Handbook* refers members to the website for information or questions about preventive health guidelines, and printed copies of the guidelines are available upon request. Various methods are used to encourage members to follow the preventive health guidelines, including information on the website, in the *Member Handbook*, targeted mailings, and phone calls. The *Healthy Lifestyles* page on the BlueChoice website provides printable information on a variety of medical and behavioral health topics, and various community and members-only events throughout South Carolina provide forums for distributing information.

Policy SC_GAXX_015, Grievance Process: Members, defines processes for grievance acknowledgement, but contradictory information is noted in the *Member Handbook* and *Provider Manual*. This issue was identified during the previous EQR. Also, erroneous information regarding the grievance resolution timeframe is noted in the *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment. Grievance file review findings include issues of one untimely acknowledgement letter, one resolution letter with insufficient information, and one file with no evidence of investigating the grievance. Three files should have been referred for investigation as potential quality of care issues but were not identified as potential quality of care issues or referred for investigation. As a result of the onsite discussion, BlueChoice initiated investigations of the issues in these grievances.

BlueChoice contracts with DSS Research, a certified CAHPS survey vendor, to conduct both the Child and Adult surveys. The sample sizes for the *Member Satisfaction Survey* are adequate and meet the NCQA minimum sample size and number of valid surveys (at

least 411), but the response rates are below the NCQA target of 40%. Actual response rates are 27.59% (Adult) and 25.65% (Child). CCME provided recommendations to increase response rates.

BlueChoice received "Met" scores for 85% of the standards for the Member Services Review. Scores of "Partially Met" are due to documentation in the *Member Handbook*, documentation of grievance resolution timeframes, documentation of grievance record retention requirements, and grievance file findings. One standard is scored as "Not Met" due to an uncorrected deficiency related to documentation of the grievance acknowledgement process identified during the previous EQR.

Figure 5: Member Services Findings

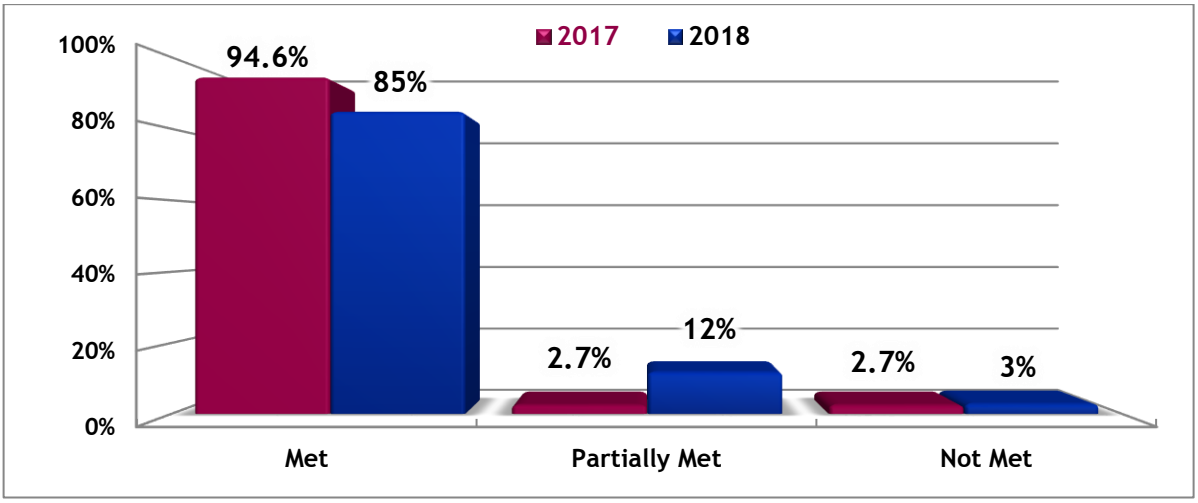


Table 5: Member Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information	Not Met	Partially Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: the procedure for filing and handling a grievance	Partially Met	Not Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Grievances	Timeliness guidelines for resolution of the grievance as specified in the contract	Met	Partially Met
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Partially Met
	The MCO applies the grievance policy and procedure as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- BlueChoice provides a host of extra benefits including free Girl Scout memberships, free Youth Explorer Program through Boy Scouts of America, discounts on Boys and Girls Club fees, the Blue Book Club℠, discounts for Jenny Craig®, etc.
- Multiple programs are in place to provide education, support, and assistance to pregnant members.

Weaknesses

- Onsite discussion confirmed prior authorization is required for a member to obtain a second opinion from an out-of-network provider; however, this is not reflected in the information on second opinions on page 84 of the *Member Handbook*.
- The following issues exist in information regarding copayments:
  - The copayment of $3.40 for dental services, which is documented in the *Member Handbook and Provider Manual*, is not documented on the website.
  - The *Member Handbook* and website define a $3.40 copayment for outpatient care at a hospital (other than ER); but page 20 of the *Provider Manual* states the copayment is $3.30.
- The *Member Handbook* and the BlueChoice website do not inform members they will be notified of their provider's termination from the network.
- Page 69 of the *Member Handbook* indicates BlueChoice may deny a member's request to disenroll for cause. Refer to the *SCDHHS Contract, Section 3.13.1.4.4* and *Section 3.13* which indicate all disenrollment decisions are made by SCDHHS.
- Page 29 of the *Member Handbook* states members can find out more about a Primary Care Physician (PCP) or a specialist such as specialty, medical school, residency

training, or board certification by visiting the American Medical Association and American Board of Medical Specialties websites. CCME found the following issues:

  - For the American Medical Association website, members are instructed to click "Patients" then "Doctor Finder." No option exists to select "Patients" on this website. Further, when searching for "Doctor Finder" on the website, the search returned over 1400 results and a place to look up a specific doctor is not available.
  - For the American Board of Medical Specialties website, members are instructed to select "Consumers;" however, no option to select "Consumers" exists on this website.

- The *Member Handbook* page with the heading of "Evidence of Coverage" includes an email address for the Customer Care Center (dmself-referral@bluechoicesc.com); however, onsite discussion revealed this is not an email for the Customer Care Center.
- Page 38 of the *Member Handbook* provides a description of EPSDT services; however, the periodicity table or schedule is not included in the *Member Handbook*. Instead, members are instructed to visit the BlueChoice website or call the Customer Care Center to find out more about the Preventive Health Guidelines. Members may not understand that EPSDT services are addressed in the Preventive Health Guidelines on the website (due to the difference in terminology).
- CCME confirmed the Preventive Health Guidelines are available on BlueChoice's website; however, they are not easy for members to locate.
- The *Member Handbook* provides information regarding Advance Directives and instructs members to contact the Lieutenant Governor's Office on Aging to obtain Advance Directive forms. Applicable telephone numbers are provided. Page 73 of the *Member Handbook* contains a link to obtain Advance Directive forms and to file a complaint online. However, options to obtain Advance Directive forms and to file a complaint are not available when navigating to the specified link.
- Policy SC_CSPC_002, Customer Service, states the Customer Care Center is staffed from 8:00 AM to 6:00 PM, Eastern Standard Time, excluding state holidays. As written, this sounds as if the Customer Care Center is staffed seven days a week excluding state holidays; however, onsite discussion confirmed the Customer Care Center is staffed Monday through Friday except state-declared holidays.
- The sample sizes for the *Member Satisfaction Survey* are adequate and meet the NCQA minimum sample size and number of valid surveys, but response rates are below the NCQA target of 40%. Actual response rates are 27.59% (Adult) and 25.65% (Child).
- Page 85 of the *Member Handbook* and the BlueChoice website use the term "action" instead of "adverse benefit determination" when defining a grievance. Refer to the *SCDHHS Contract, Section 9.1 (a)* and *Federal Regulation §438.400 (b)*.

- Policy SC_GAXX_015, Grievance Process: Members, indicates verbal grievances that can be resolved within one business day by Customer Care staff receive verbal acknowledgement. All other grievances are acknowledged in writing within five calendar days of the receipt date. Issues include:
  - The *Member Handbook*, page 63, states, "After we receive your grievance by phone or in the mail, we'll send you an Acknowledgment Letter within five calendar days." This seems to indicate all grievances are acknowledged in writing and is an issue identified during the previous EQR.
  - Page 91 of the *Provider Manual* also sounds as if all grievances are acknowledged in writing—it states BlueChoice will send a written acknowledgement of the grievance to the member within five calendar days from the date BlueChoice receives the grievance.
- The *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment incorrectly state grievances are resolved within 90 calendar days from the date of receipt.
- Per onsite discussion, grievance records are retained for a minimum of seven years but usually 10 or more years, and electronic records are retained indefinitely. Page eight of Policy SC_GAXX_015, Grievance Process: Members, references retention timeframes of three years and five years. The policy also says, "Electronic files are maintained for longer than 5 years." This is vague and does not clearly convey the timeframe for retention of electronic records. The *SCDHHS Contract, Section 19.35.3*, requires retention of grievance records for a period of no less than 10 years.
- Minor issues noted by CCME in the grievance files include one untimely acknowledgement letter; one resolution letter does not address all findings of the investigation and could be misinterpreted by the reader; and one file does not contain evidence of the investigation of the grievance.
- Three grievance files contained allegations that should have been referred for investigation as potential quality issues. Health plan staff reviewed the files during and after the onsite and concurred that these grievances should have been referred for investigation as potential quality incidents.

Quality Improvement Plans

- Revise the website to include the copayment of $3.40 for dental services.
- Update the *Provider Manual* to reflect a copayment amount of $3.40 for non-emergency services provided in the Emergency Room (ER).
- Remove the statement that BlueChoice may deny the request for disenrollment for cause from page 69 of the *Member Handbook*.

- Correct the links in the *Member Handbook* to find out more about a PCP or a specialist such as specialty, medical school, residency training, or board certification.
- Remove the incorrect email address (dmself-referral@bluechoicesc.com) from the *Member Handbook* "Evidence of Coverage" page.
- Correct the link in the *Member Handbook* to obtain Advance Directive forms online. Consider removing the link as an alternative because members are already directed to call the Lieutenant Governor's Office on Aging to obtain forms and a telephone number is provided.
- Clarify the *Member Handbook*, page 63, and the *Provider Manual*, page 91, to indicate verbal grievances that can be resolved within one business day are acknowledged verbally and all other grievances are acknowledged in writing within five calendar days.
- Correct the grievance resolution timeframe in the *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment.
- To comply with requirements of the *SCDHHS Contract, Section 19.35.3*, revise Policy SC_GAXX_015, Grievance Process: Members, to reflect a record retention timeframe of at least 10 years. Ensure BlueChoice, Amerigroup, and any applicable delegated entities comply with this record retention timeframe.
- Define and implement processes to ensure staff recognize and refer grievances that contain potential quality incidents for investigation.

Recommendations

- Revise page 84 of the *Member Handbook* to include that a second opinion from an out-of-network provider requires prior authorization.
- Update the *Member Handbook* and website to inform members that they will be notified of a provider's termination from the BlueChoice network. Include the timeframe and method of notification and that the health plan will assist members to select a new provider if needed.
- Update page 38 of the *Member Handbook* to inform members that EPSDT services are addressed in the Preventive Health Guidelines on the website or include the recommended schedule for EPSDT services in the *Member Handbook*.
- Include the Preventive Health Guidelines in the Members area of the website in a prominent, easy to find location.
- Revise Policy SC_CSPC_002, Customer Service, to clarify that the Customer Care Center's hours of operation are 8:00 AM to 6:00 PM, Eastern Standard Time, Monday through Friday, excluding state holidays.

- Continue working with DSS Research to increase response rates for Adult and Child surveys. Consider adding a reminder to call center scripts or allowing a longer timeframe for additional reminders to be sent and phone call surveys to be conducted. CCME also recommends that BlueChoice decide and document an internal goal to increase response rates (such as a 3% or 4% increase each year).
- Revise page 85 of the *Member Handbook* and the BlueChoice website to use the term "adverse benefit determination" instead of "action" in the definition of a grievance.
- Ensure acknowledgement letters are sent within the required timeframe, that resolution letters include all appropriate information, and that files contain evidence of the investigation of the grievance.

D. Quality Improvement

CCME conducted a review of Quality Improvement (QI) sections including the QI program description, program evaluation, committee minutes, policies, performance measures, and performance improvement project (PIP) validation.

BlueChoice provided the *2018 Medicaid Quality Management Program Description* as evidence the program is designed to provide the structure and key processes for ongoing improvements of care and services BlueChoice provides to members and providers. Similar discrepancies regarding the frequency for policy review are found in the 2018 program description that were noted in the 2017 program description reviewed last year. Throughout the program description there is inconsistency regarding the name BlueChoice uses for their quality program. For example, on page four the program is listed as Quality Assessment and Performance Improvement Program. On page five, the program is listed as Quality Management Program.

The Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) continue to have authority and accountability for developing and implementing the QI program. Both committees report directly to BlueChoice's Managed Care Oversight Committee, and the oversight committee reports to the Board of Directors.

The QI Program Description, page 30, discusses the adoption of the clinical and preventive health guidelines. It does not mention monitoring provider compliance. Policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption, and Distribution, and Policy SC_PCXX_006, Preventive Health Guidelines – Review, Adoption, Distribution, and Performance Monitoring, discuss performance monitoring through medical record audits. BlueChoice's policies are not clear about what is monitored. Also, the medical record audit tools do not include monitoring the clinical practice guidelines.

Performance Measure Validation

CCME conducted a validation review of the Health Effectiveness Data Information Set (HEDIS®) performance measures following CMS developed protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

BlueChoice uses Inovalon, a certified software organization, for calculation of HEDIS rates. The comparison from the previous to the current year revealed strong increases in MMR, Flu vaccinations, Lead Screening in Children, and Adolescent Well Care visits, among a few other measures. The measures that decreased were Statin Adherence and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia among a few others. The current rate and last year's rate, along with the change in rate, are presented in *Table 6: HEDIS Performance Measure Data*.

Table 6: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	84.03%	83.06%	-0.97%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	70.37%	73.38%	3.01%
Counseling for Nutrition	57.18%	60.88%	3.70%
Counseling for Physical Activity	47.69%	51.85%	4.16%
Childhood Immunization Status (cis)			
DTaP	70.37%	75.46%	5.09%
IPV	85.65%	88.89%	3.24%
MMR	82.87%	93.06%	10.19%
HiB	78.24%	83.33%	5.09%
Hepatitis B	83.80%	86.11%	2.31%
VZV	82.41%	91.44%	9.03%
Pneumococcal Conjugate	74.54%	79.17%	4.63%
Hepatitis A	79.63%	87.27%	7.64%
Rotavirus	71.76%	74.07%	2.31%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Influenza	34.72%	46.30%	11.58%
Combination #2	65.28%	68.98%	3.70%
Combination #3	63.89%	66.90%	3.01%
Combination #4	61.34%	65.05%	3.71%
Combination #5	55.56%	57.87%	2.31%
Combination #6	28.94%	37.27%	8.33%
Combination #7	53.94%	56.48%	2.54%
Combination #8	28.70%	37.04%	8.34%
Combination #9	25.69%	34.03%	8.34%
Combination #10	25.46%	33.80%	8.34%
Immunizations for Adolescents (ima)			
Meningococcal	62.88%	62.04%	-0.84%
Tdap	84.92%	80.32%	-4.60%
HPV	15.81%	14.58%	-1.23%
Combination #1	62.65%	60.19%	-2.46%
Combination #2	--	13.43%	NA
Lead Screening in Children (lsc)	57.41%	68.06%	10.65%
Breast Cancer Screening (bcs)	49.34%	49.19%	-0.15%
Cervical Cancer Screening (ccs)	50.12%	52.47%	2.35%
Chlamydia Screening in Women (chl)			
16-20 Years	43.47%	47.43%	3.96%
21-24 Years	54.76%	61.76%	7.00%
Total	47.48%	53.16%	5.68%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	77.39%	76.93%	-0.46%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.33%	28.74%	1.41%
Pharmacotherapy Management of COPD Exacerbation (pce)			

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Systemic Corticosteroid	48.71%	63.86%	15.15%
Bronchodilator	69.79%	71.81%	2.02%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	47.14%	54.41%	7.27%
5-11 Years: Medication Compliance 75%	23.57%	26.05%	2.48%
12-18 Years: Medication Compliance 50%	46.72%	50.97%	4.25%
12-18 Years: Medication Compliance 75%	21.83%	24.12%	2.29%
19-50 Years: Medication Compliance 50%	60.87%	51.43%	-9.44%
19-50 Years: Medication Compliance 75%	31.88%	30.48%	-1.40%
51-64 Years: Medication Compliance 50%	72.22%	60.61%	-11.61%
51-64 Years: Medication Compliance 75%	44.44%	39.39%	-5.05%
Total: Medication Compliance 50%	48.91%	53.27%	4.36%
Total: Medication Compliance 75%	24.32%	26.52%	2.20%
Asthma Medication Ratio (amr)			
5-11 Years	79.42%	82.57%	3.15%
12-18 Years	65.40%	72.34%	6.94%
19-50 Years	47.22%	51.75%	4.53%
51-64 Years	37.14%	56.25%	19.11%
Total	69.28%	73.77%	4.49%
Effectiveness of Care: Cardiovascular Condition			
Controlling High Blood Pressure (cbp)	43.49%	41.92%	-1.57%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	80.95%*	61.29%	-19.66%
Received Statin Therapy: 21-75 Years (Male)	71.71%	74.59%	2.88%
Statin Adherence 80%: 21-75 Years (Male)	76.15%	55.80%	-20.35%
Received Statin Therapy: 40-75 Years (Female)	76.42%	77.06%	0.64%
Statin Adherence 80%: 40-75 Years (Female)	65.96%	50.38%	-15.58%
Received Statin Therapy: Total	73.82%	75.77%	1.95%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Statin Adherence 80%: Total	71.43%	53.16%	-18.27%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.49%	83.10%	-1.39%
HbA1c Poor Control (>9.0%)	47.92%	47.92%	0.00%
HbA1c Control (<8.0%)	45.37%	44.91%	-0.46%
Eye Exam (Retinal) Performed	30.32%	34.72%	4.40%
Medical Attention for Nephropathy	91.90%	92.13%	0.23%
Blood Pressure Control (<140/90 mm Hg)	51.39%	52.55%	1.16%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	57.99%	60.64%	2.65%
Statin Adherence 80%	52.08%	48.21%	-3.87%
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	62.50%	58.89%	-3.61%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	41.45%	42.53%	1.08%
Effective Continuation Phase Treatment	26.53%	25.72%	-0.81%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	32.89%	37.61%	4.72%
Continuation and Maintenance (C&M) Phase	44.24%	51.68%	7.44%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	NR	NR	NA
7-Day Follow-Up	NR	NR	NA
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	NA	37.20%	NA
7-Day Follow-Up	NA	24.86%	NA

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NA	5.26%	NA
7-Day Follow-Up: 13-17 Years	NA	5.26%	NA
30-Day Follow-Up: 18+ Years	NA	15.15%	NA
7-Day Follow-Up: 18+ Years	NA	10.47%	NA
30-Day Follow-Up: Total	NA	14.66%	NA
7-Day Follow-Up: Total	NA	10.21%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	79.18%	75.51%	-3.67%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	61.82%	69.23%	7.41%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	100.00%*	66.67%	-33.33%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	55.70%	59.82%	4.12%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	20.00%	11.11%	-8.89%
6-11 Years	23.53%	18.97%	-4.56%
12-17 Years	22.48%	23.81%	1.33%
Total	22.70%	21.76%	-0.94%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	84.24%	86.94%	2.70%
Digoxin	59.26%	55.00%	-4.26%
Diuretics	83.78%	87.00%	3.22%
Total	83.83%	86.80%	2.97%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.49%	1.56%	-0.93%
Appropriate Treatment for Children with URI (uri)	84.64%	84.40%	-0.24%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	21.96%	24.40%	2.44%
Use of Imaging Studies for Low Back Pain (lbp)	70.88%	75.41%	4.53%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	NA	NA
6-11 Years	2.86%	2.27%	-0.59%
12-17 Years	3.23%	0.00%	-3.23%
Total	3.13%	0.71%	-2.42%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	77.46%	75.74%	-1.72%
45-64 Years	86.52%	85.99%	-0.53%
65+ Years	100.00%	100.00%	0.00%
Total	80.31%	78.79%	-1.52%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.37%	96.08%	-0.29%
25 Months - 6 Years	85.07%	85.99%	0.92%
7-11 Years	85.76%	87.49%	1.73%
12-19 Years	83.69%	85.73%	2.04%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	38.68%	31.52%	-7.16%
Engagement of AOD Treatment: 13-17 Years	26.42%	14.13%	-12.29%
Initiation of AOD Treatment: 18+ Years	32.27%	36.40%	4.13%
Engagement of AOD Treatment: 18+ Years	7.62%	9.59%	1.97%
Initiation of AOD Treatment: Total	32.69%	36.12%	3.43%
Engagement of AOD Treatment: Total	8.85%	9.85%	1.00%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	85.98%	89.56%	3.58%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Postpartum Care	70.56%	70.53%	-0.03%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	100.00%*	71.43%	-28.57%
6-11 Years	11.11%*	48.39%	37.28%
12-17 Years	17.31%	24.59%	7.28%
Total	19.18%	35.35%	16.17%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	7.68%	9.56%	1.88%
21-40 Percent	5.09%	4.11%	-0.98%
41-60 Percent	7.49%	7.88%	0.39%
61-80 Percent	15.69%	15.22%	-0.47%
81+ Percent	64.06%	63.23%	-0.83%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.98%	2.78%	1.80%
1 Visit	2.45%	2.31%	-0.14%
2 Visits	2.21%	3.01%	0.80%
3 Visits	5.64%	3.24%	-2.40%
4 Visits	7.11%	9.72%	2.61%
5 Visits	17.16%	10.65%	-6.51%
6+ Visits	64.46%	68.29%	3.83%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	64.87%	66.17%	1.30%
Adolescent Well-Care Visits (awc)	36.34%	47.45%	11.11%

*NB: Not a benefit; NR: Not reported; NA: Data not available; *: small denominator*

Performance Improvement Project Validation

CCME validated PIPs in accordance with CMS protocol *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates

components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects - one clinical and one non-clinical. The clinical project is titled "Childhood Immunizations Combo 3 and Lead Screening." The non-clinical project is titled, "Access and Availability of Care." *Table 7, Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 7: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Access and Availability of Care	96% High Confidence in Reported Results	83% Confidence in Reported Results
Childhood Immunizations Combo 3 and Lead Screenings	95% High Confidence in Reported Results	83% Confidence in Reported Results

The Access and Availability of Care PIP scored 96% last year and 83% this year. The Combo 3 and Lead Screenings PIP scored 95% last year and 83% this year. Last year, the Access and Availability of Care PIP had an issue with the baseline and benchmark rate definitions. For the Childhood Immunization PIP, BlueChoice had issues last year with baseline and benchmark rate definitions as well as the Combo 3 improvement. Those issues are still present in the most recently submitted documentation. During the onsite, BlueChoice stated that the Combo 3 and Lead Screening PIP is in the process of being closed. The report does not contain a statement about it being closed or retired; therefore, it is validated as an active project. For both PIPs, there is a lack of documentation on interventions. The recommendations for each of the two PIPs are displayed in *Table 8, Performance Improvement Project Errors and Recommendations.*

TABLE 8: Performance Improvement Project Errors and Recommendations

Section	Reasoning	Recommendation
Childhood Immunizations Combo 3 and Lead Screenings		
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions are documented, although new interventions have not been initiated since 2014.	Initiate and implement new interventions to increase Combo 3 rates, specifically, as they are not improving.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The benchmark is lower than the baseline goal. The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal.	Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).
Is there any statistical evidence that any observed performance improvement is true improvement?	Combo 3 does not have statistically significant improvement from baseline, although Lead Screening rates have increased significantly from baseline when compare to Re-measurement 2.	Continue to adapt interventions focused on increasing Combo 3 vaccination rates.
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	Sustained improvement occurred for Lead Screening, but improvement has not occurred for Combo 3.	Interventions should focus on Combo 3 improvement, as lead screening has improved but Combo 3 has not improved.
Access and Availability of Care		
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions are documented in the report, but no new interventions have been initiated since 2016.	Initiate new interventions to determine if rates improve based on new efforts.

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The benchmark is lower than the goal. The goal should be a short-term goal, whereas the benchmark is the long-term goal. For Indicator #2, the numerator and denominator do not equate to the percentages presented.	Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal). The benchmark and long-term goal terms are essentially the same element. The goal is a short-term goal, and the benchmark is the long-term goal. For Indicator #2, verify percentage calculations are accurate using the numerator and denominator given.
Was there any documented, quantitative improvement in processes or outcomes of care?	No, both rates decreased instead of improving (increasing).	Implement new interventions to improve rates.

Details of the validation of the performance measures and PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 6, Quality Improvement Findings, indicate that 87% of the standards received a "Met" score.

Figure 6: Quality Improvement Findings

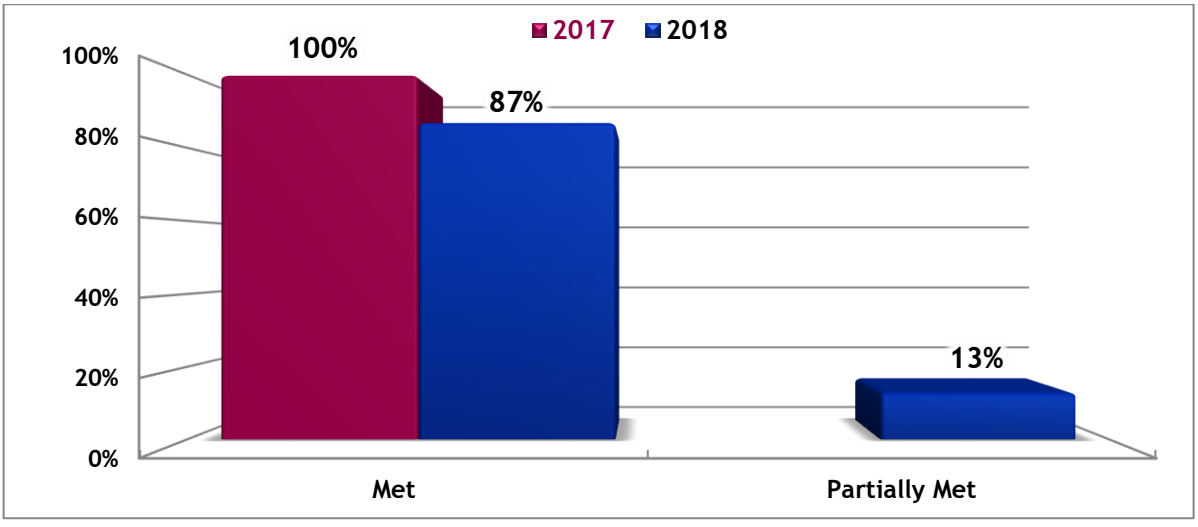


TABLE 9: Quality Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines	Met	Partially Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- BlueChoice uses certified software for HEDIS calculations.
- The Clinical Quality Improvement Committee is well-attended by network providers.

Weaknesses

- Two discrepancies are noted in the *2018 Medicaid Quality Management Program Description*:
  - Page 24, under Policies and Procedures Supporting QAPI Programs, indicates that policies and procedures and other materials are reviewed annually and revised when indicated. Page 34, under Policies & Procedures, states policies and procedures are reviewed, at a minimum, bi-annually. Onsite discussion confirmed the policies are reviewed at least annually.
  - Throughout the program description there is confusion regarding the name BlueChoice uses for its Quality program. On page four the program is listed as Quality Assessment and Performance Improvement Program. On page five the program is listed as Quality Management Program.
- Policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption, and Distribution, and Policy SC_PCXX_006, Preventive Health Guidelines – Review, Adoption, Distribution, and Performance Monitoring, discuss performance monitoring through medical record audits. It is not clear in the polices what is monitored. Also, the medical record audit tools do not include monitoring the clinical practice guidelines.
- The chairman for the Clinical Quality Improvement Committee and the Service Quality Improvement Committee is not noted in the committee minutes. Also, there is a discrepancy in the QI Program Description regarding the chairman for the Service Quality Improvement Committee.

- PIP documentation does not have evidence of new interventions planned to address lack of improvement in rates. The issues regarding the benchmark and baseline goals (or short-term goal) rates were not revised as recommended in the previous EQR.

Quality Improvement Plan

- Update policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption, and Distribution, and Policy SC_PCXX_06, Preventive Health Guidelines – Review, Adoption, Distribution and Performance Monitoring, to include the monitoring process conducted to monitor provider compliance with the clinical and preventive health guidelines. If medical record review will be used for monitoring, update the medical record data collection tools to include the monitoring of the guidelines.
- Correct the issues identified in the PIPs.

Recommendation

- Correct the following in the *2018 Medicaid Quality Management Program Description*:
  - the frequency of policies and procedure reviews
  - the program name throughout the document
- Indicate on each committee's minutes who chairs the committee. Also, correct the discrepancy in the QI Program Description *regarding* who chairs the SQIC.

E. Utilization Management

Blue Choice has contracted with Amerigroup Partnership Plan to implement administrative services for Utilization Management (UM). The *UM Program Description* gives an overview of the UM Department's structure and methodology for conducting UM processes, and outlines the purpose, operations, and lines of responsibility within the Health Care Management (HCM) Department. Members and providers can obtain information about the UM program in several ways, such as the *Member Handbook*, *Provider Manual*, and the BlueChoice website.

The Amerigroup Medical Director has oversight of UM activities. Departmental and corporate policies provide guidelines on operationalizing standards and complying with requirements. The Clinical Quality Improvement Committee reviews and approves UM activities and the UM Work Plan, which is incorporated into the Quality Improvement (QI) Work Plan.

UM approval and denial files indicate decisions are made based on medical necessity criteria by the appropriate staff person in a timely manner. BlueChoice has an inter-rater reliability (IRR) process for physicians, nurses, pharmacists, and non-licensed associates to ensure staff making service authorizations are consistently applying UM standards and

criteria. Processes are in place to monitor and detect under- or over-utilization of medical services.

BlueChoice has established policies and procedures addressing standard and expedited appeals of adverse benefit determinations by members and providers. Information regarding appeals processes and requirements is found in the *Member Handbook*, *Provider Manual*, and on the BlueChoice website. CCME identified inconsistencies in documentation of the receiving area for mailed member appeal requests. These inconsistencies are noted in the *Member Handbook*, *Provider Manual*, the *Member Appeals Request Form*, and the adverse benefit determination notice. CCME provided recommendations to address this finding.

BlueChoice uses several processes to identify members who may benefit from Case Management (CM), such as data mining and provider referrals. CM policies and procedures, as well as the *UM Program Description*, provide guidance to staff performing CM activities. CCME could not identify how BlueChoice conducts an initial screening of each enrollee's needs within 90 days of enrollment nor could CCME identify a Transition Coordinator. CCME provided recommendations to address these issues. CM files reflect appropriate activities are being conducted as required and according to established policies.

As noted in *Figure 7: Utilization Management Findings* BlueChoice received "Met" scores for 93% of the UM standards. Standards that received a score of "Partially Met" or "Not Met" are addressed in the Weaknesses section.

Figure 7: Utilization Management Findings

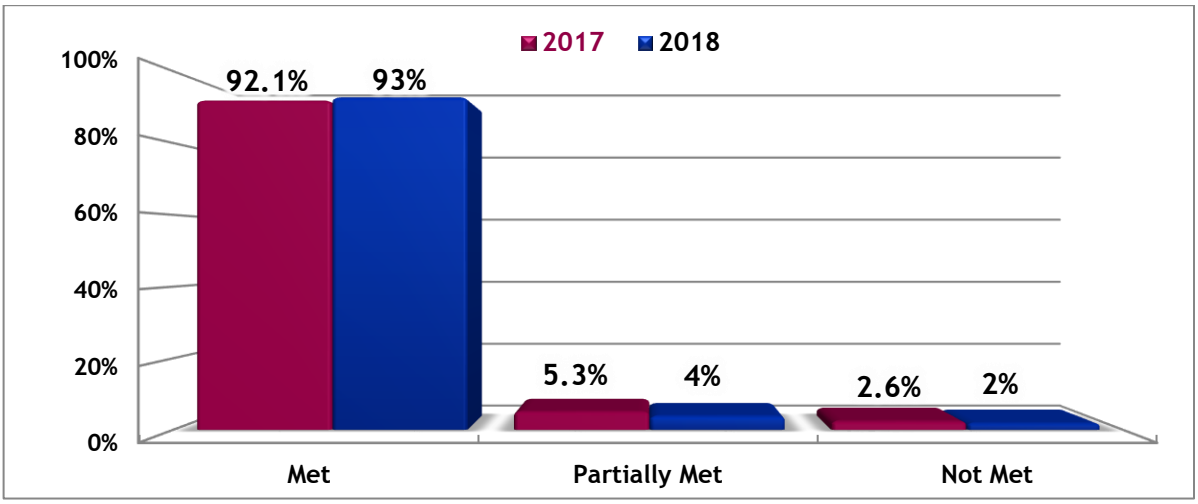


TABLE 10: Utilization Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including: timeliness guidelines for resolution of the appeal as specified in the contract the procedure for filing an appeal	Not Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Policies clearly indicate and differentiate clinical from non-clinical staff and licensed from non-licensed staff.
- Approval letters and adverse benefit determination notices clearly indicate the service being requested.
- Analysis of over- and under-utilization is comprehensive and demonstrates a focus on monitoring, evaluating, and addressing utilization issues.

Weaknesses

- Review of desk materials does not identify how the Preferred Program is communicated to providers.
- The Pharmacy Lock-In Program, referenced in Policy SC-PMXX-025, Medicaid Pharmacy Lock-In Program, is the same as the Rx Safe Choice Program referenced in the *Provider Manual*. Using different names for the same program could lead to confusion.
- The allowance for members to obtain specialty medication from a local pharmacy in specific circumstances is not communicated in any policy, the *Pharmacy Program Description*, or *Provider Manual*.
- The *Member Handbook* does not contain information regarding specialty pharmaceuticals.

- Instructions for mailing the *Member Appeal Request Form* to BlueChoice has the receiving department listed differently in the following documents:
  - The *Member Handbook*, page 65, says to address it to the "Appeals Coordinator"
  - The *Provider Manual*, page 90, says to addresses it to the "Attn: Grievance and Appeals"
  - The *Member Appeals Request Form* says to address it to "Attn: Grievance Department"
  - In two separate areas, the adverse benefit determination notice provides instruction to mail it to the "Grievance and Appeals Dept." and "Attn: Appeals Coordinator"
- The timeframe to file an appeal is incorrectly documented in the adverse benefit determination notice and the *Member Handbook*.
- Documents did not identify how BlueChoice meets the *SCDHHS Contract, Section 5.1.1* requirement that an initial screening of each enrollee's needs is conducted within 90 days of the effective date of enrollment for all new enrollees.

Quality Improvement Plan

- Correct the timeframe to file an appeal in the *Notice of Adverse Benefit Determination* and the *Member Handbook*.
- Revise Policy SC-GAXX-051, Member Appeals Process, and the *Member Handbook* to include all elements of the contract requirement applicable to when the contractor extends the appeals timeframe. Refer to the *SCDHHS Contract, Section 9.1.6.1.5.1, Section 9.1.6.1.5.2., and Section 9.1.6.1.5.3.*
- BlueChoice does not have a designated Transition Coordinator.

Recommendations

- Include a description of the *Preferred Provider Program* in the *Provider Manual* and other provider resources as appropriate.
- Use the same name for the Lock-In Program in Policy SC-PMXX-025, Medicaid Pharmacy Lock-In Program, the *Provider Manual*, and other applicable documents.
- Revise an applicable pharmacy policy and/or program description and the *Provider Manual* to address the process for allowing members to obtain specialty pharmaceutical medication from a local pharmacy in clinically urgent situations. Refer to the *SCDHHS Contract, Section 4.2.21.4.*
- Include information regarding specialty pharmaceuticals in the *Member Handbook*.

- Revise the mailing addresses for appeal requests in the *Member Handbook*, *Provider Manual*, *Member Appeal Request Form*, and the *Notice of Adverse Benefit Determination* letter to have consistent language for the receiving department.
- Address in a policy or other applicable document how the requirement for an initial screening of member needs for all new members is being met.
- Include all elements of the contract requirement applicable to when the contractor extends the appeals timeframe in Policy SC-GAXX-051, Member Appeals Process, and the *Member Handbook*.
- Designate a Transition Coordinator to fulfill the requirement indicated in the *SCDHHS Contract, Section, 5.6.2.*

F. Delegation

Policy HP 003-12, Oversight of Delegated Activities, outlines the procedure for oversight of all delegated activities. All delegated organizations have a written, signed agreement designating the delegated activities with the compliance and oversight requirements included.

BlueChoice's delegated services are defined in *Table 11, Delegated Entities and Services*.

Table 11: Delegated Entities and Services

Delegated Entities	Delegated Services
• Greenville Hospital System • Roper St. Francis Physicians Network • VSP • Medical University of South Carolina • Department of Mental Health • Palmetto Health USC Medical Group • AnMed Health	Credentialing/Recredentialing
Anthem	Various Medical Review Services, Federal External Reviews, Special Investigations Unit (SIU) Reviews
Express Scripts, Inc. (ESI)	Pharmacy Services

Policy HP 003-12, Oversight of Delegated Activities, states that oversight of a delegated organization occurs at least annually and includes a review of compliance with accreditation standards, contractual requirements, written policies and procedures, and any incentive structures in place.

Policy MCD-10, Credentialing Delegation, defines the process for delegated credentialing activities which includes a pre-delegation audit for proposed delegates and annual oversight for entities where credentialing has been delegated. The delegates must meet both BlueChoice HealthPlan Medicaid and SCDHHS credentialing standards.

Evidence of annual oversight conducted within the last year was provided for all delegated entities. The oversight reports and tools are comprehensive; however, Policy MCD-10 does not address the SSDMF as a query item even though it is addressed in the tool. In addition, for delegated credentialing, the *Terminated for Cause List* needs to be added to the tool, Credentialing Requirements for Vendor document, and the policy as a query item.

As indicated in *Figure 8, Delegation Findings* one of the two standards in the Delegation section is scored as "Partially Met."

Figure 8: Delegation Findings

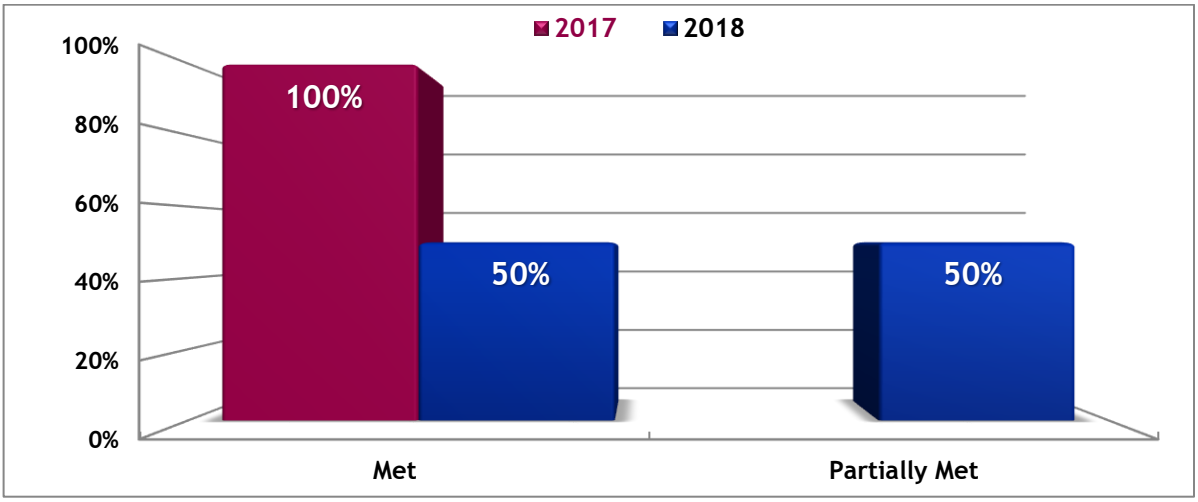


TABLE 12: Delegation Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- Policy MCD-10 does not address the SSDMF as a query item even though it was addressed in the delegation oversight tool.
- For delegated credentialing, the *Terminated for Cause List* is not reflected as a query requirement in the delegation oversight tool, Credentialing Requirements for Vendor document, and the Policy MCD-10 as a query item.

Quality Improvement Plan

- Update Policy MCD-10, Credentialing Delegation, to include the SSDMF as a query item.
- For delegated credentialing, add the *Termination for Cause List* as a query item to Policy MCD-10, the Credentialing Requirements for Vendor document, and the delegation oversight tool.

G. State Mandated Services

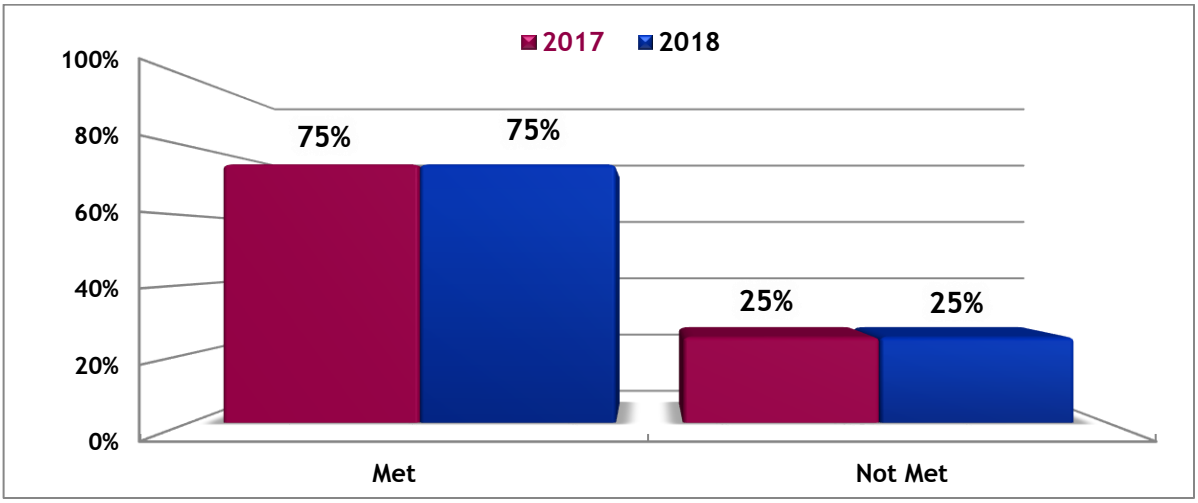
For the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, BlueChoice encourages providers to follow the recommendations of the Centers for Disease Control and to use the American Academy of Pediatrics Bright Futures tool kits which include the EPSDT guidelines. Network providers are informed of the EPSDT program and immunizations schedule through the *Provider Manual*, *Provider Bulletins*, and other communications. Quarterly *Gaps in Care* reports are disseminated to providers by Provider Network Services staff and the Quality Management Department. Provider compliance with provision of EPSDT services and required immunizations is monitored through random medical record reviews conducted by nurse reviewers. A signed refusal statement must be placed in the medical record as evidence of voluntary refusal of an assessment/service by the member or the member's responsible party. Providers must report immunization data to the South Carolina Department of Health and Environmental Control's State Immunization Information System.

BlueChoice provides all core benefits required by the *SCDHHS Contract*.

CCME identified deficiencies from the previous EQR which have not been addressed. These include discrepancies in documentation of the Compliance Committee's membership and errors in documentation of grievance acknowledgement processes.

BlueChoice received "Met" scores for 75% of the standards for the State-Mandated Services section of the EQR. One standard is scored as "Not Met" due to uncorrected deficiencies identified during the previous EQR.

Figure 9: State Mandated Services



Weaknesses

- Several deficiencies from the previous EQR were not addressed. These include:
  - Discrepancies in documentation of the Compliance Committee's membership.
  - Errors in documentation of the grievance acknowledgement process.

Quality Improvement Plans

- Ensure all deficiencies identified in the EQR are addressed and the corrections are implemented.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

March 19, 2018

Mr. Daniel Gallagher
BlueChoice HealthPlan
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Gallagher:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2018 External Quality Review (EQR) of BlueChoice HealthPlan is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **May 17th and 18th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **April 2, 2018.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2017 and 2018.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from March 2017 through March 2018. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of March 2017 through March 2018.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of March 2017 through March 2018. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of March 2017 through March 2018, including any medical information and approval criteria used in the decision. Please include

prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://eqro.thecarolinascenter.org
- **should be submitted in the categories listed**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Appendix A, Quality Management Committee Structure and Appendix F, Population Health Management Strategy referenced on page 27 of the 2018 Medicaid Quality Management Program Description.
3. Several credentialing and/or recredentialing files were missing information or need explanation. See attached list.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**BlueChoice**
Name of PM	**ALL HEDIS MEASURES**
Reporting Year	2017 (MY2016)
Review Performed	05/2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® TECHNICAL SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

Plan's Measure Score	80
Measure Weight Score	80
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**ACCESS AND AVAILABILITY OF CARE (NON CLINICAL)**
Reporting Year:	2017
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Annual preventive care rate is below the HEDIS 50th percentile and rate of getting care is declining.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**		
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection occurrence is noted.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Not Met**	Interventions are documented in the report, but no new interventions have been initiated since 2016. ***Quality Improvement Plan:*** *Initiate new interventions to determine if rates improve based on new efforts.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis is performed according to the data analysis plan.

Component / Standard (Total Points)	Score	Comments
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	The benchmark is lower than the goal. The goal should be a short-term goal, whereas the benchmark is the long-term goal. For Indicator #2, the numerator and denominator do not equate to the percentages presented. ***Quality Improvement Plan:*** *Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal). The benchmark and long-term goal terms are essentially the same element. So, the goal should be a short-term goal and the benchmark is the long-term goal. For Indicator #2, ensure percentage calculations are accurate using the numerator and denominator given.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and remeasurement 1 data were presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Follow-up analyses were noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology was used at repeat measurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	No, both rates decreased instead of improving (increasing). ***Quality Improvement Plan:*** *Implement new interventions to improve rates.*
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement was reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement was reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement was reported.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file for AAP.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	0
Step 8		
8.1	5	5
8.2	10	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	104
Project Possible Score	125
Validation Findings	83%

AUDIT DESIGNATION
Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**CHILDHOOD IMMUNIZATIONS COMBO 3 AND LEAD SCREENING (CLINICAL)**
Reporting Year:	2017
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Rates are below the Nationally Healthy People target rates.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined in documentation.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection will occur once per year.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data Analysis will be once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Not Met**	Interventions are documented, although new interventions have not been initiated since 2014. ***Quality Improvement Plan:*** *Initiate and implement new interventions to increase Combo 3 rates as they are not improving.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis of findings is performed according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	The benchmark is lower than the baseline goal. The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal. ***Quality Improvement Plan:*** *Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).*

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Statistical comparison was documented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analyses and follow up activities are noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Yes, although sampling was adjusted as per HEDIS specifications.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	For Combo 3, the rate increased initially and then decreased to below the baseline rate for most recent remeasurement. For lead screening, the rate has been increasing from baseline.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvements appear to be a result of the intervention for Lead Screening; improvements were not shown for Combo 3 in the most recent remeasurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Not Met**	Combo 3 does not have statistically significant improvement from baseline, although Lead Screening rates have increased significantly from baseline when compare to Remeasurement 2. ***Quality Improvement Plan:*** *Continue to adapt interventions focused on increasing Combo 3 vaccination rates.*
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Partially Met**	Sustained improvement occurred for Lead Screening, but improvement has not occurred for Combo 3. ***Recommendation****: Interventions should focus on Combo 3 improvement.*

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	HEDIS rates verify the rates documented in PIP.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	0
Step 8		
8.1	5	5
8.2	10	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	5	3
Activity 2	20	20

Project Score	113
Project Possible Score	136
Validation Findings	83%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**BLUECHOICE**
Survey Validated	**CAHPS ADULT**
Validation Period	2017
Review Performed	05/2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation:*2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. Blue Choice had a sample size of 1,755. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol, and are clear and appropriate. Documentation: *2076 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 27.6%. The target response rate according to NCQA is 40.0%. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research* *Recommendation: Implement strategies to increase response rates such as email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures are followed. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data is analyzed. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions supported by findings. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 27.6%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored above the ANM Average for 2017 on Customer Service, Getting Needed Care, Getting Care quickly, and How Well Doctors Communicate, but scored below the ANM Average for 2017 on Shared Decision Making. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access and timeliness of healthcare was conducted via survey. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation: *2017 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

CCME EQR Survey Validation Worksheet

Plan Name	**BLUECHOICE**
Survey Validated	**CAHPS CHILD**
Validation Period	2017
Review Performed	05/2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation:*2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population is clearly defined. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Sample frame is clearly defined. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	Blue Choice has a sample size of 2,145. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures used to select the sample. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol, and are clear and appropriate. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 25.7%. The target response rate according to NCQA is 40.0%. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research* *Recommendation: Implement strategies to increase response rates such as email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data is analyzed. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 25.7%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored below the ANM Average for 2017 on Customer Service. The plan scored above the ANM Average for 2017 on Getting Needed Care, Getting Care quickly, How Well Doctors Communicate, and Shared Decision Making. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness of healthcare is included in survey. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation: *2017 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**BlueChoice**
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Onsite discussion confirmed policies are reviewed annually. However, the Quality Improvement (QI) Program Description, page 33, states Quality Management (QM) Department policies and procedures are reviewed, at a minimum, biennially. Also, the Medicaid Business Unit policy titled, "Policy and Procedure Reviews" states, "By default all P&Ps are reviewed biennially (every 2 years); however, this may be changed to an annual review cycle depending on state contract, accreditation, and department of ownership's purview." This policy includes state-specific exceptions on pages 7 and 8; however, it does not include information specific to South Carolina.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the QI Program Description to reflect that policies are reviewed at least annually. Add a South Carolina exception to the "Policy and Procedure Reviews" policy indicating policies are reviewed annually.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Tim Vaughn serves as President and Chief Operating Officer for BlueChoice HealthPlan Medicaid (BlueChoice).
1.2 Chief Financial Officer (CFO);	X					Jennifer Thorne is the Chief Financial Officer.
1.3 * Contract Account Manager;	X					Amy Bennett is the Contract Account Manager located in South Carolina (SC).
1.4 Information Systems personnel;						Michele Carrera is the Chief Information Officer.
1.4.1 Claims and Encounter Manager/ Administrator,	X					Nicholas Von Gersdorff is the Encounters Manager and Christopher Kearney is the Claims Manager. Both are located in Virginia (VA).
1.4.2 Network Management Claims/ Encounter Processing Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Utilization Management (Coordinator, Manager, Director);	X					Victoria McNeil Brock is the Utilization Management Director. She is a Registered Nurse located in SC. Ms. Brock is supported by Maureen Daniels, Manager II (Prior Authorization and Concurrent Review) and Michael Brownlee, Manager I (Case Management).
1.5.1 Pharmacy Director,	X					Jonathan Jones, a licensed pharmacist located in SC, is the Pharmacy Director.
1.5.2 Utilization Review Staff,	X					Most utilization review (UR) functions are conducted in SC. It appears that sufficient staff is in place to conduct UR functions.
1.5.3 *Case Management Staff,	X					Most case management (CM) functions are conducted by home-based staff in SC. It appears that sufficient staff is in place to conduct CM functions.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Damian Bridges serves as the Quality Director and is located in SC. Per the QI Program Description, the local Clinical Quality Management staff includes the Medicaid Director, Director of Clinical Quality, and Medical Director. They share responsibility for the overall development and delivery of the quality program with responsibility for: •clinical/service quality programs •HEDIS/quality data management and reporting •clinical/service quality outcomes •credentialing •accreditation •compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corporate Clinical Quality Management staff from the Medicaid Business Unit provides leadership and support to the local team. Amerigroup Behavioral Health staff oversees Quality Management for behavioral health (BH) for BlueChoice.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Scott Timmons is the Provider Service Manager, located in SC.
1.7.1 *Provider Services Staff,	X					Brian Butler is the Senior Director, Provider Outreach. Shay Looker is the Manager Provider Relations. They are supported by Provider Relations Representatives throughout SC.
1.8 *Member Services Manager;	X					Donna Williams is the Member Service Manager and located in SC.
1.8.1 Member Services Staff,	X					Iesha Young is Manager I, Customer Care. Ashley Hobbs is Acting Manager, Customer Care, and Angela Waples is Acting Operations Expert, Customer Care. They are supported by 21 Customer Care Representatives. Currently the Customer Care Call Center is located in Savannah, Georgia, but this location is being eliminated and functions will be transferred to locations in Denver, Colorado, and Indianapolis, Indiana.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 *Medical Director;	X					Imtiaz Khan, DO, is the Medical Director. This is a full-time position located in SC. Kim Cooley, DO, is an additional Medical Director located in Ohio whose duties include medical necessity review for authorization requests. Tracey Smithey, MD, is a psychiatrist who serves as Medical Director for Behavioral Health.
1.10 *Compliance Officer;	X					Rod Johnson is the Compliance Officer for BlueChoice. He is located in SC and reports to Tim Vaughn, President and COO. Edward Stubbers is the Chief Compliance Officer for Anthem.
1.10.1 Program Integrity Coordinator;	X					Debra Teeter is the Program Integrity Coordinator and is located in SC.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Amy Bennett serves as the Interagency Liaison.
1.12 Legal Staff;	X					Melanie Joseph serves as legal counsel for BlueChoice.
1.13 Board Certified Psychiatrist	X					Tracey Smithey, MD is a board-certified psychiatrist located in Tampa FL. She is licensed in SC.
1.14 Post-payment Review Staff.	X					Post-Payment Review staff includes 8 Registered Nurses who are also Certified Coders. They cover the needs of all markets.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Operational relationships of MCO staff are clearly delineated.	X					An organizational chart is in place and denotes key positions for both BlueChoice and Amerigroup. For positions not identified as key positions, the organizational chart is difficult to understand. For example, it is difficult to determine if staff members are BlueChoice or Amerigroup employees and employee locations are unclear. *Recommendation: Revise the organizational chart to indicate whether each staff member is a BlueChoice or Amerigroup employee and denote staff locations.*
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					As discussed during the onsite visit, job descriptions define minimum education and experience requirements for all positions. In addition, licensure and educational requirements for UM staff are detailed in program descriptions for utilization management, case management, and disease management.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Anthem policy requires 98% of claims to be processed within 30 days of receipt and 99% of claims to be processed within 90 days of receipt. A review of claims data reveals 90% of claims are paid within 14 days of receipt, 98% are paid within 30 days of receipt, and 99% within 90 days of receipt. In addition to providing timely claims processing, random claims audits are performed by a corporate review team to verify claims accuracy and adherence to internal and contractual requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Anthem leverages a multitude of electronic systems to accept and process Medicaid data for BlueChoice. Systems are in place to electronically process paper submissions also.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					The systems servicing BlueChoice update eligibility files daily. The unique SCDHHS-assigned ID number is used to track member enrollment and disenrollment. Additionally, BlueChoice systems are capable of tracking members throughout multiple Medicaid product lines.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					A detailed network diagram of the WGS claims system used for BlueChoice was provided, as well as a detailed diagram of the peripheral systems used to service the health plan. Documentation indicates the systems are run on hardware capable of fulfilling claims processing requirements of the *SCDHHS Contract*. Anthem analyzes claims, membership, enrollment, and provider data with certified HEDIS software to produce reports the required by the *SCDHHS Contract*.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					The security details provided by Anthem for BlueChoice demonstrate a focus on data security and indicate Anthem practices the rule of "minimum necessary required" when assigning access to data. Anthem provided a comprehensive workforce information security overview that establishes a security baseline for staff servicing the BlueChoice plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Anthem staff and partners servicing the BlueChoice plan are assigned only the minimum data access required, use unique identifiers (login IDs) to authenticate to claims systems, and use login IDs that are assigned to specific system roles.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					ISCA documentation demonstrates business continuity measures are in place for the systems servicing the BlueChoice plan. Additionally, Anthem provided documentation from a recent disaster recovery (DR) test. The DR test was successful in restoring claims systems, but the DR documents indicate that Anthem is working to reduce recovery times to meet its recovery time objectives. *Recommendation: Focus on verifying systems and administrative tools function properly and current prior to DR testing. Attention to regular system maintenance will help reduce disaster recovery issues.*
I D. Compliance/Program Integrity						
1. The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					The *BlueChoice HealthPlan Medicaid Compliance Plan*, the *Anthem Special Investigations Unit Antifraud Plan*, and policies define processes to guard against fraud, waste, and abuse (FWA). The *Compliance Plan* indicates a last revision date of 12/14/2016. CCME confirmed during onsite discussion that the document was recently revised and is expected to receive approval from the Compliance Committee in June 2018.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *Anthem Special Investigations Unit Antifraud Plan* was last updated in September 2017. BlueChoice's corporate standards of business conduct are outlined in its Code of Conduct document titled, *Our Values*.
2. Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training.	X					Various policies define processes and requirements for employee and subcontractor training. The Compliance Plan also addresses employee compliance training.
3. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.			X			The BlueChoice HealthPlan Compliance Committee oversees the development and implementation of the Compliance Plan. The committee also monitors, reviews, and assesses the effectiveness of the Compliance Plan. The *Compliance Committee Charter* indicates a quorum is met with 3 members from each organization (BlueChoice and Amerigroup). CCME noted discrepancies in the committee's membership across the *Compliance Committee Charter*, the *QI Program Description*, and the *Committee Membership List* for the Medicaid Compliance Committee. This is a deficiency identified during the previous EQR. CCME noted a discrepancy in the frequency of Compliance Committee meetings. The *BlueChoice Medicaid Compliance Committee Charter* indicates the committee meets monthly but no less than 10 times yearly. The QI Program Description, page 20, states the committee meets monthly but no less than 4 times yearly. However, during onsite discussion of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						this discrepancy, BlueChoice confirmed the Compliance Committee meets quarterly and not monthly. Committee minutes reflect quarterly meetings. *Quality Improvement Plan: Revise all lists of Compliance Committee membership for consistency. Correct the frequency of Compliance Committee meetings in the BlueChoice HealthPlan Medicaid Compliance Committee Charter and QI Program Description.*
4. The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities.	X					The *Special Investigations Unit Antifraud Plan* defines processes and requirements for claims auditing and recovery activities. Reporting requirements are included.
5. The MCO has policies and procedures that define how investigations of all reported incidents are conducted.	X					*The Special Investigations Unit Antifraud Plan* defines processes and requirements for investigations of suspected fraud, waste, and abuse.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MCD-09, Privacy and Confidentiality, defines processes for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Pages 1 and 9 indicate all new employees, consultants, and contractors are required to attend a training session on the corporate compliance program, *Our Values*, which includes a HIPAA Privacy overview, definition of protected health information (PHI), and what constitutes an impermissible use or disclosure of PHI. The policy states this training must

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be completed before any access to PHI is granted; however, the QI Program Description, page 35, states all employees undergo HIPAA training within 60 days of the date of hire. Onsite discussion revealed new employees receive HIPAA training on the first day of employment, prior to receiving a computer, ID badge, etc. Participation in HIPAA training is tracked electronically and reported to the Compliance Department. Annual refresher training is required, and management can require more frequent training for individual employees as necessary. Staff, consultants, external committee members, etc. sign confidentiality agreements annually. *Recommendation: Update the QI Program Description, page 35, to reflect that new employees receive HIPAA/confidentiality training prior to being granted access to PHI.*

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				The *Credentialing Program Description* and several policies address the BlueChoice credentialing processes. The information is comprehensive; however, the following issues exist: •The *Medicaid Credentialing Program Plan* does not mention querying the *Terminated for Cause List* at credentialing and recredentialing for providers and facilities. •Policies MCD-04, Initial Credentialing and MCD-05, Recredentialing do not address querying the *Terminated for Cause List*. *Quality Improvement Plan: Update the Credentialing Program Plan and Policies MCD-04 and MCD-05 to address querying the Terminated for Cause List at credentialing and recredentialing.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The BlueChoice Credentialing Committee is chaired by Dr. Lloyd Kapp, Medical Director. He has the responsibility for all credentialing and recredentialing activities, including approval of policies and procedures. Additional committee members include the Vice President of Medical Affairs and nine network providers with specialties including internal medicine, pediatrics, chiropractic, surgery, pulmonology, OB/GYN, and dental. Only network providers on the committee have voting privileges

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and a quorum is met with three network providers. A review of committee minutes showed participation by the voting members and a quorum was met at each meeting reviewed. Credentialing approval activities related to behavioral health are the responsibility of the Companion Benefit Alternatives (CBA) Credentialing Committee. The CBA Credentialing committee has a total of 10 voting members with three of the committee members participating as external providers.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files are organized, and for the most part contain appropriate documentation. Any issues are discussed in the respective section.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;			X			The credentialing files reviewed do not show evidence of query of the *Terminated for Cause List* required by the *SCDHHS Contract, Section 11.11.11.2* and *SCDHHS Policy and Procedure (P & P) Guide, Section 11.2.12.1*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure credentialing files contain proof of query of the Terminated for Cause List.
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);		X				A review of credentialing files shows inconsistency in reflecting proof of queries of the SSDMF. BlueChoice indicated at the onsite it began applying to have access to the SSDMF query site in April 2017 and had problems with access that were out of its control. BlueChoice implemented a process in February 2018. *Quality Improvement Plan: Ensure credentialing files contain evidence of query of the SSDMF.*
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files are organized, and obtain most of the appropriate documentation. Any issues are discussed in the respective section.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;			X			The recredentialing files reviewed do not show evidence of query of the *Terminated for Cause List* required by the *SCDHHS Contract, Section 11.11.11.2 and SCDHHS Policy and Procedure (P & P) Guide, Section 11.2.12.1.* *Quality Improvement Plan: Ensure recredentialing files contain proof of query of the Terminated for Cause List.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);		X				A review of recredentialing files showed inconsistency in reflecting proof queries of the SSDMF. BlueChoice indicated at the onsite it began applying to have access to the SSDMF query site in April 2017 and had problems with access that were out of its control. BlueChoice implemented a process in February 2018. *Quality Improvement Plan: Ensure recredentialing files contain evidence of query of the SSDMF.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy SC_GAXX_022, Processing Internal Potential Quality Issues, defines the process to address Internal Potential Quality Issues (IPQIs) and Preventable Adverse Events (PAEs) that arise in relation to practitioners or groups and institutions contracted with Amerigroup to deliver health care services to members for matters concerning the quality of care and surgical care or ethical transgressions. The Amerigroup Grievance and Appeal (G&A) Department is responsible for the process that identifies, investigates, and resolves IPQIs and PAEs. Policy SC_GAXX_021, Clinical Quality Incident Severity Level Determination, defines the process for tracking and assigning severity levels to cases after a grievance and appeal investigative review. This includes review by the Medical Director who determines the severity level determination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination, defines the process used to restrict, suspend, or terminate participating practitioners based on issues of quality of care, quality of service, or credentialing. Providers are offered appeal rights, and outcomes of investigations are reported to appropriate outside agencies.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing, defines the process to evaluate health care delivery organizations for approval in to the BlueChoice HealthPlan or CBA network. The policy does not address querying the *Terminated for Cause List*. CCME's review of the organizational files reflect appropriate documentation except for proof of query of the *Terminated for Cause List*. *Quality Improvement Plan: Update Policy MCD-06, Health Care Delivery Organizations – Credentialing/ Recredentialing, to reflect the need to query the Terminated for Cause List. Ensure credentialing/ recredentialing files contain proof of query of the Terminated for Cause List.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				CCME reviewed multiple policies about ongoing monitoring such as Policy MCD-03, Ongoing Monitoring of Sanctions; Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination; and Policy SC_PNXX_309, Excluded and Debarred Providers. The *Credentialing Program Description* was also reviewed. However, it is difficult to understand

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						BlueChoice's processes due to multiple policies that fragment the information related to ongoing monitoring. The only document that addresses the SSDMF is the Ongoing Monitoring of Sanctions and Complaints Desk Procedure received during the onsite. Additionally, the *Terminated for Cause List* is not addressed as a query for ongoing monitoring in any of the reviewed policies, the *Credentialing Program Description* or the Ongoing Monitoring of Sanctions and Complaints Desk Procedure. *Quality Improvement Plan: Ensure the SSDMF and the Terminated for Cause List are addressed in a policy and/or policies related to ongoing monitoring.* *Recommendation: Consider consolidating policies to clarify the ongoing monitoring process.*
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy MCD-11, Medicaid Access/Availability Standard, defines the access standard for PCPs as one provider within 30 miles for 95% of the population. The PCP category is defined as family practitioners, pediatricians, and internal medicine physicians. The GEO Access reports for August 2017 show that 100% of members have access to their PCP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *BlueChoice HealthPlan of South Carolina 2017 Medicaid Availability Analysis Primary Care Physicians & High Volume Specialists* report shows that BlueChoice exceeded the 95% access goal for PCPs with 100% of members having access to their PCP within 30 miles.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MCD-11, Medicaid Access/Availability Standard, defines the access standard for specialists (including hospitals) as one specialist within 50 miles for 95% of the population. Pharmacies are measured as one with 30 miles for 95% of the population. The GEO Access reports received in the desk materials complied with the guidelines and also met the population access goals. The *BlueChoice HealthPlan of South Carolina 2017 Medicaid Availability Analysis Primary Care Physicians & High Volume Specialists* report shows BlueChoice exceeded the goal of 95% access to High Volume/High Impact Specialists within the specified 30 or 50-mile radius. The goals are met for hospital and pharmacy with 100% of members having access within 30 miles. The *BlueChoice HealthPlan of South Carolina 2018 Medicaid Availability Analysis for Behavioral Health Practitioners* showed for the standard of one practitioner within 50 miles the goal was met or exceeded by 99.9%. There are no barriers identified for the 2017 year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy MCD-11, Medicaid Access/Availability Standard states that BlueChoice will submit bi-annual GEO Access reports to SCDHHS as required by the contract. Ad-hoc GEO Access reports are run regularly to assess business needs.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy SC_CLLS_018, Cultural and Linguistic Program, defines the objectives and processes to ensure culturally and linguistically appropriate health care services to all members. In addition, the *Provider Manual* addresses cultural competency and a *Caring for Diverse Populations* toolkit is available on the website. The *BlueChoice HealthPlan of South Carolina Medicaid 2017 Cultural Needs Assessment* was conducted to evaluate the network of physicians in meeting the members' cultural, racial, ethnic and linguistic needs. Results showed zero complaints received in 2016 related to language, ethnicity/ culture or race categories. In 2016, Member Services received 987 calls for language interpretation. The overall review of the Member Ratings from the CAHPS data confirms a large majority of the plan members do not have a problem finding a doctor who meets their cultural/linguistic/ethnic needs.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					The *Provider Directory* is available on the website with easy to use search options and the availability to print a directory from the website. Onsite discussion confirmed the *Provider Directory* information is updated on a weekly basis.
3.Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy MCD-11, Medicaid Access/Availability Standards, defines physician office accessibility standards which comply with contract guidelines. Providers are educated through training presentations, onsite office visits, and the *Provider Manual*. BlueChoice measures PCP appointment and after-hours accessibility annually. CCME received the *BlueChoice HealthPlan Medicaid Practitioner Access Analysis, January 1, 2017 to December 31, 2017*, in the desk materials. PCPs and high-volume specialists are measured for appointment access through identified questions in the Adult and Children's CAHPs Survey, and through analyzing grievances. Results of the surveys showed the Child CAHPs Survey met the performance goal of 85% for routine and urgent appointments, and appointments for high-volume specialists. However, the 85% goal was not met for the Adult CAHPs survey measurement for routine and urgent appointment, and high-volume specialists. During onsite discussion, CCME suggested BlueChoice drill down to assess appointment compliance at the provider level. This will allow identification of specific non-compliant providers that need intervention.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The After-Hours Access survey results indicated the goal of 90% for provider offices was met with an overall compliance of 93.23%. A total of 235 providers were surveyed with 16 providers found noncompliant. These providers were referred to Provider Education for further intervention. Policy PN001, Access/Availability Standards for CBA Network, defines the appointment access standards for behavioral health providers. The following discrepancy was noted between the policy and the behavioral health access indicators listed in the *BlueChoice HealthPlan Medicaid Practitioner Access Analysis, January 1, 2017 to December 31, 2017*: •The report defines the access indicator for routine care as "within two weeks (10 days); however, Policy PN001 defines routine office visits as "within 10 working days." *Quality Improvement Plan: Define and implement a process to evaluate appointment access at the provider level to ensure provider compliance to appointment standards. Ensure consistency between documents regarding the behavioral health appointment access standard for routine care.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The results of the Telephonic Provider Access Study conducted by CCME reflect calls are answered successfully 69% of the time (185 out of 269) when omitting 40 calls answered by personal or general voicemail messaging services. When compared to last year's results of 45%, the increase in successful answer rate is statistically significant (p<.001).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy MCD-01, Education of Contracting Providers, states an onsite educational session is scheduled with each office when the contract is signed for new providers. During this onsite educational session, the BlueChoice HealthPlan Medicaid Provider Education Department presents an overview of the product and provides plan specific contact information. The new provider orientation training covers various topics such as Provider Responsibilities, Access and Availability Standards, Fraud, Waste and Abuse and the False Claims Act, covered benefits, etc.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Provider education includes performing onsite orientations, providing educational materials and references, updating the providers through the use of web and special mailings, annual workshops, and routine onsite contacts.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC_PCXX_006, Preventive Care, defines the process for review, adoption, distribution and performance monitoring of Amerigroup adopted preventive health guidelines. The guidelines are reviewed and approved locally by the CQIC. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines are reviewed annually or whenever pertinent or new evidence is available.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.		X				Amerigroup collaborates with BlueChoice to post the preventive health guidelines to the member and provider website. Information on the availability of the preventive health guidelines is included in the *Provider Manual*. Newly contracted providers are informed of the preventive health guidelines through their welcome materials. Printed copies are available upon request. A preventive health guidelines brochure was provided in the desk materials and is loaded to the website. The brochure appears to be outdated with a date of May 2016. *Quality Improvement Plan: Ensure the preventive health guidelines brochure reflects current adopted preventive guidelines.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.		X				Behavioral health clinical practice guidelines are listed on the website at: https://www.bluechoicescmedicaid.com/providers/membereligibilityandbenefits/behavioralhealthbenefits/behavioralhealthclinicalpracticeguidelines.aspx Some of the guidelines appear to address preventive behavioral health services; however, the guidelines are outdated with references such as "Reviewed/Approved 12/2013." *Quality Improvement Plan: Update the website to reflect current behavioral health preventive and clinical practice guidelines.*
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC QMXX-048, Clinical Practice Guidelines Review, Adoption, and Distribution, defines the process of adoption, review and approval of clinical practice guidelines (CPG) for medical and behavioral health, developed by Amerigroup on behalf of BlueChoice Medicaid. The CPGs are updated at least annually or when changes are made to national guidelines. The CQIC reviews and adopts the CPGs as updates are made.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.		X				Clinical practice guidelines are mentioned in the *Provider Manual* and are loaded to the BlueChoice Medicaid website. A written copy of the guidelines is available upon request. Newly contracted providers are educated through welcome materials; however, several issues are noted: •Behavioral health clinical practice guidelines are not addressed in the *Provider Manual*. •There is a link to behavioral health guidelines in the Member/Eligibility section of the Provider Website and not where the other Clinical Practice Guidelines are listed. •The website has a clinical practice guideline matrix loaded that appears to be updated, but other guidelines listed on the same web page have outdated references such as "reviewed/approved 5/2012, reapproved 12/2013." It is difficult to understand if these are a part of the adopted guidelines or why dates are not current. *Quality Improvement Plan: Remove outdated clinical practice guidelines from the website. Address Behavioral Health Guidelines in the Provider Manual and on the Medicaid website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy SC QMXX-080, Monitoring Continuity and Coordination of Medical Care, defines the process for Amerigroup to promote the coordination and continuity of care that members receive across settings or transitions of care. PCPs are responsible for coordinating their members' care among the medical and behavioral practitioners and providers treating the same patient. Various methods are established to verify that member medical health care and behavioral health care are coordinated as needed. Annually, Amerigroup collects and analyzes data to identify opportunities to collaborate between medical and behavioral healthcare practitioners.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.		X				The *Medical Record Review Audit Tool* received in the desk materials does not appear to address all areas of review stated in Policy MCD-12, Medical Record Review for Documentation Standards, and the *SCDHHS Policy and Procedure Guide, Section 15.8 O.* Examples include: •Signed and dated consent forms •Documentation of emergency and/or after-hours encounters and follow-up

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC_QMXX_105, Medical Record Review, also addresses the review process and onsite discussion confirmed this is the most recent policy. The review tool associated with this policy is different than the review tool received for Policy MCD-12; however, the tool does not address "signed and dated consent forms" as required. CCME suggested BlueChoice have one policy to address the medical record review process and to ensure the review tool addresses all contract requirements. *Quality Improvement Plan: Ensure the medical record review policies address the current review process and the review tools address all contract requirements.* *Recommendation: Consider consolidating policies to clarify the medical record review process.*
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record review for documentation standards is monitored and data is reviewed annually to identify trends and recommend interventions to improve overall compliance. The *BlueChoice HealthPlan Medicaid Medical Record Review for 2017* indicated a change in the previous review practice. In the past, practices with more than 100 members that had not a compliance audit were targeted, but there was not a process in place to ensure that medical records for each provider in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the practice were reviewed. In 2017, BlueChoice chose to review the medical records of 5 members per provider so that the audit findings accurately reflected the practice as a whole. Claims and enrollment analyses were done to ensure the members chosen were assigned to and had at least 2 visits with the corresponding provider during the audit year. In addition, BlueChoice implemented a new audit tool that evaluates the notation of pediatric & adult health maintenance as well as documentation standards. For 2017, BlueChoice reviewed 14 groups/36 providers with a total of 180 medical records. The average score was 85%, down from 97% in 2016. While the 2017 overall average did meet the goal of ≥ 80%, the average score decreased by 12% year over year. BlueChoice noted that the changes in the methodology and the audit tool may have accounted for the variance in scoring. Three practices fell below 80% and corrective action included an onsite visit, education, and re-audit within 12 months. Twelve practices did not respond to requests for the records and were escalated to Provider Relations, with follow up to be included in the 2018 medical record audit.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy SC_ QMXX_104, Member Rights and Responsibilities, defines rights to which members are entitled and responsibilities as a member of BlueChoice. The policy indicates member rights and responsibilities are included in the *Member Handbook*, *Provider Manual*, on the BlueChoice website, and via *Member Newsletters*. Onsite discussion confirmed member rights are included in the *Member Newsletter* annually.
2. Member rights include, but are not limited to, the right:	X					Member rights are included in Policy SC_ QMXX_104, Member Rights and Responsibilities, the *Member Handbook*, the *Provider Manual*, and on the BlueChoice website.
2.1 To be treated with respect and with due consideration for his or her dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:		X				Per onsite discussion, a member packet including the *Member Handbook*, a document of changes to the *Member Handbook*, the *Member ID Card*, an introductory letter, and accessory information is sent to new members within 14 business days of enrollment. Changes to the *Member Handbook* are listed in an *Evidence of Coverage Change Control Log* which is maintained on the BlueChoice website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Issues resulting in the score of "Partially Met" as well as actions to correct those issues are addressed in the standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The *Member Handbook* defines coverage and benefits for members, including benefits above those required by SCDHHS. Extra benefits include, but are not limited to: •Free Girl Scout memberships/free Youth Explorer Program through Boy Scouts of America •Discounts on Boys and Girls Club fees •Blue Book ClubSM •Discounts for Jenny Craig®
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						Information regarding the availability of second opinions is found on page 84 of the *Member Handbook*. Onsite discussion confirmed prior authorization is required for a member to obtain a second opinion from an out-of-network provider. This is not reflected on page 84 of the *Member Handbook*. *Recommendation: Revise page 84 of the Member Handbook to include that a second opinion from out-of-network provider requires prior authorization.*
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						Information regarding copayment amounts was compared in the *Member Handbook*, the *Provider Manual*, and on the BlueChoice website. The following issues were identified: •The website does not include the $3.40 copayment for dental services which is documented in the *Member Handbook* and *Provider Manual*. •The *Member Handbook* and website define a $3.40 copayment for outpatient care at a hospital (other than ER); but page 20 of the *Provider Manual* states there is a copayment of $3.30 for non-emergent services provided in the ER. Members who are not subject to copayments are defined in the *Member Handbook*, *Provider Manual*, and on the website *Quality Improvement Plan: Revise the website to include the copayment of $3.40 for dental services. Update the copayment amount for non-emergent services provided in the ER to $3.40 in the Provider Manual.*
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The *Member Handbook* indicates which services require prior authorization and provides a narrative discussion of general prior authorization requirements and processes.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The *Member Handbook* provides definitions of emergent and urgent care and examples of when members should seek these types of care. Information includes that prior authorization is not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						required for emergent care. For emergency conditions, members are instructed to go to the nearest emergency room or call 911, and that the 24-Hour Nurseline is staffed by registered nurses who can help determine the type of care needed.
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *Member Handbook* provides an overview of the *Preferred Drug List* (PDL), explains that some drugs in the PDL require prior authorization and/or have limitations, and includes medication copayments. An overview of coverage requirements and copayments for durable medical equipment is also included.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The *Member Handbook* states that members will be notified of changes in benefits 30 calendar days before the change. The *Member Handbook* does not inform members that they will be notified of their provider's termination from the network. This is also not on the BlueChoice website. BlueChoice's processes for notifying members of a provider's termination were discussed during the onsite visit and are detailed in Policy SC_PNXX_303, Provider Termination and Member Notification. *Recommendation: Update the Member Handbook and website to inform members they will be notified of a*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider's termination from the BlueChoice network. Include the timeframe and method of notification and that the health plan will assist members to select a new provider if needed.
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						Page 69 of the *Member Handbook* states members may ask to disenroll without reason during the first 90 days of enrollment. It further states members may request disenrollment at any time with good reason, but if BlueChoice denies the reason the member can request a State Fair Hearing. This is an incorrect statement, as BlueChoice does not deny or approve the member's disenrollment request. Per the *SCDHHS Contract, Sections 3.13.1.4.4,* "All disenrollment for cause decisions are made by the Department." The *SCDHHS Contract, Section 3.13*, states, "A Member may be disenrolled from the CONTRACTOR's Health Plan only when authorized by the Department." *Quality Improvement Plan: Remove the statement that BlueChoice may deny the request for disenrollment for cause from page 69 of the Member Handbook.*
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Directions to find the online provider directory are included in the *Member Handbook*. Members can download a copy from the "Find a Doctor" page on the website or call the Customer Care Center to request a printed copy. The searchable online provider directory allows users to search for providers and/or facilities by name, hospital affiliation, specialty, gender, distance, location, accepting new patients, board certification, and language. Page 29 of the *Member Handbook* states members can find out more about a PCP or a specialist such as specialty, medical school, residency training, or board certification by visiting the following: •American Medical Association (AMA) at www.ama-assn.org. Members are instructed to click "Patients" then "Doctor Finder (the button on the right side of the page)." No option exists to click "Patients" on this website. When searching for "Doctor Finder," the search returns over 1400 results and a place to look up a specific doctor is not available. •American Board of Medical Specialties (ABMS) at www.abms.org. Members are instructed to select "Consumers;" however, no option to select "Consumers" exists. An option under "Verify Certification" links to the CertificationMatters.org website, which allows a physician's board certification to be verified. *Quality Improvement Plan: Revise links in the Member Handbook to direct the user to the correct locations to find out more about a PCP or a specialist*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						such as specialty, medical school, residency training, or board certification.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						Page 61 of the *Member Handbook* addresses providing members with assistance in other languages, and states BlueChoice uses an interpreter service for more than 150 languages (including American Sign Language). BlueChoice offers health education items in Spanish, multilingual Customer Care Center staff, 24-hour access to interpreter services (including sign language and face-to-face interpreters), and multilingual network providers. Members may request translation of member materials by calling the Customer Care Center or emailing GBD.Interpret@amerigroup.com.
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The *Member Handbook* includes the toll-free telephone number/TTY number and business hours for the Customer Care Center and the 24-Hour Nurseline. The handbook also includes the BlueChoice mailing address and fax number for the Customer Care Center. Members are informed they can send secure messages to the Customer Care Center through the member portal on the BlueChoice website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *Member Handbook* page with the heading "Evidence of Coverage" includes an email address for the Customer Care Center (dmself-referral@bluechoicesc.com); however, onsite discussion revealed this is not an email for the Customer Care Center. *Quality Improvement Plan: Remove the incorrect email address (dmself-referral@bluechoicesc.com) from the Member Handbook's "Evidence of Coverage" page.*
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						Page 38 of the *Member Handbook* provides a description of EPSDT services; however, the periodicity table or schedule is not included in the *Member Handbook*. Members are instructed on page 57 to visit the BlueChoice website or call the Customer Care Center to find out more about the Preventive Health Guidelines. Members may not understand that EPSDT services are addressed in the Preventive Health Guidelines (due to the different terminology). CCME confirmed the Preventive Health Guidelines are available on BlueChoice's website. They are found through a link at the bottom of the "Benefits for Children and Adults" in the "Members" section of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						website. In their current location, the guidelines are difficult for members to locate. *Recommendation: Update page 38 of the Member Handbook inform members that EPSDT services are addressed in the Preventive Health Guidelines on the website or include the recommended schedule for EPSDT services in the Member Handbook. Include the Preventive Health Guidelines in the Members area of the website in a prominent, easy to find location.*
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can receive assistance with executing an advance directive;						The *Member Handbook* provides information Advance Directives including Living Wills and Healthcare Powers of Attorney. Members are instructed to contact the Lieutenant Governor's Office on Aging to obtain Advance Directive forms. Applicable telephone numbers are provided. Page 73 of the *Member Handbook* contains an incorrect link to obtain Advance Directive forms and to file a complaint online. When navigating to the specified link, options to obtain Advance Directive forms and to file a complaint were not found. *Quality Improvement Plan: Correct the link in the Member Handbook to obtain Advance Directive forms online. Consider the alternative of removing the link because members are already directed to call the Lieutenant Governor's Office on Aging to obtain forms and a telephone number is provided.*
1.22 Information on how to report suspected fraud or abuse;						The *Member Handbook* defines fraud, waste, and abuse (FWA) terminology and provides examples of each. Members can anonymously report suspected

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						FWA via the multiple methods provided in the *Member Handbook*, including calling the Customer Care Center or the BlueChoice Fraud Hotline, faxing the *BlueChoice Fraud Referral Form*, writing to BlueChoice HealthPlan Medicaid, calling the South Carolina Medicaid Fraud Hotline, and emailing medicaidfraudinvestigations@amerigroup.com or fraudres@scdhhs.gov. The home page of the website includes a prominent link to FWA information.
1.23 Additional information as required by the contract and by federal regulation;						
1.24 The MCO notifies each member, at least once per year, of their right to request a Member Handbook or Provider Directory.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Members are notified in writing of changes to services or benefits and of a provider's termination as required by the *SCDHHS Contract*.
3. Member program education materials are written in a clear and understandable manner and meet contract requirements.	X					Amerigroup's Medicaid Marketing and Member Communications Department develops and assesses the reading level of materials distributed to members. The Flesch-Kincaid method and Health Literacy Advisor software are used to verify member materials meet the requirement of a sixth-grade reading level. BlueChoice ensures translation of member materials into threshold languages identified by SCDHHS and can have materials translated into other languages as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						needed. Materials can be provided in alternate formats such as braille, large print, or audio versions. BlueChoice assists members with visual impairments or limited reading abilities as needed to understand member materials.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					BlueChoice's Customer Care Center is currently located in Savannah, Georgia, but call center functions are scheduled for transfer to Denver, Colorado and Indianapolis, Indiana. Policy SC_CSPC_002, Customer Service, states the Customer Care Center is staffed from 8:00 AM to 6:00, PM Eastern Standard Time, excluding state holidays. This sounds as if it is staffed seven days a week. Discussion during the onsite visit confirmed the Customer Care Center is staffed Monday through Friday except for state-declared holidays. The toll-free Customer Care telephone number is available around the clock and gives instructions on what to do in an emergency and options to speak with a nurse/clinician or leave a message. Policy SC_CSPC_002, Customer Service, defines Customer Care Center access and response standards. Call center metrics reported to the SQIC confirm compliance with required standards. *Recommendation: Revise Policy SC_CSPC_002, Customer Service, to clarify that the Customer Care Center's hours of operation are 8:00 AM to 6:00 PM Eastern Standard Time, Monday through Friday, excluding state holidays.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Processes for PCP assignment to newly enrolled members are documented in Policy SC_CSPC_001, PCP Selection and Assignments.
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Per Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring, the *Member Handbook* refers members to the website for information or questions about preventive health guidelines. Printed copies of guidelines are available to members and potential members upon request. Methods to encourage members to follow the preventive health guidelines include the health plan's website, the *Member Handbook*, targeted mailings, and targeted phone calls. PCPs are encouraged to contact new and established members to encourage the members to schedule an appointment for regular preventive health care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care.	X					The *Obstetrical and Newborn Case Management Program Description* indicates most pregnant members are identified via enrollment and claims data. Other sources include Pregnancy Notification forms, continuous case finding, predictive modeling, lab results, medical/utilization management data, direct referrals to Case Management, state health risk assessments, etc. Multiple programs are in place to provide educational information related to pregnancy, childbirth, and parenting.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, specifies requirements for EPSDT services and processes for ensuring members receive the services. BlueChoice informs all EPSDT-eligible members about the EPSDT program and has processes to remind and encourage members to schedule appointments for recommended screenings, immunizations, and preventive care services using live calls, automated calls, and mailings.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Various educational and informational documents are mailed to members. The "Healthy Lifestyles" webpage provides printable information on a variety of medical and behavioral health topics, such as asthma, cervical cancer screening, stress, depression, and healthy eating. In addition, various community and members-only events are hosted throughout South Carolina.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					BlueChoice contracts with DSS Research, a certified CAHPS survey vendor, to conduct both the child and adult surveys. The sample sizes for the *Member Satisfaction Survey* are adequate and meet the NCQA minimum sample size and number of valid surveys (at least 411), but the response rates are below the NCQA target of 40%. Actual response rates are 27.59% (Adult) and 25.65% (Child). *Recommendation: Continue working with DSS Research to increase response rates for Adult and Child surveys. Consider adding a reminder to call center scripts or allowing a longer timeline to send additional reminders and to conduct phone call surveys. CCME also recommends that BlueChoice decide upon and document an internal goal to increase response rates (such as a 3% or 4% increase each year).*
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					DSS Research summarizes and details all results from the Adult and Child surveys. The results were presented to the Quality Improvement Committee (QIC) and to Providers. The *Quality Improvement Evaluation* included an analysis of the data and interventions to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					The analysis and implementation of interventions to improve member satisfaction is conducted by the QIC. According to the *2018 Quality Improvement Workplan*, results of the actions implemented in January 2018 will be available in July 2018.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Results of the CAHPS Surveys are offered to providers.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The *CAHPS Outcome Report* was presented to the QIC October 18, 2017.
III F. Grievances						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Grievance processes and requirements are documented in Policy SC_GAXX_015, Grievance Process: Members. Additional information regarding review and investigation of potential quality of care issues is documented in Policy SC_GAXX_022, Processing Internal Potential Quality Issues, and SC_GAXX_021, Clinical Quality Incident Severity Level Determination.
1.1 Definition of a grievance and who may file a grievance;	X					Policy SC_GAXX_015, Grievance Process: Members, defines a grievance as "An expression of dissatisfaction about any matter other than an adverse benefit determination." Page 85 of the *Member Handbook* and the BlueChoice website use the term "action" instead of "adverse benefit determination" when defining a grievance. Refer to the *SCDHHS Contract, Section 9.1 (a)* and *Federal Regulation §438.400 (b)*. *Recommendation: Revise page 85 of the Member Handbook and the BlueChoice website to use the term "adverse benefit determination" instead of "action" in the definition of a grievance.*
1.2 The procedure for filing and handling a grievance;			X			Policy SC_GAXX_015, Grievance Process: Members, indicates verbal grievances that can be resolved within one business day by Customer Care staff receive verbal acknowledgement. All other grievances are acknowledged in writing within five calendar days of the receipt date. Issues include: •The *Member Handbook*, page 63, states, "After we receive your grievance by phone or in the mail, we'll send you an Acknowledgment Letter within five

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						calendar days." This seems to indicate all grievances are acknowledged in writing and is an issue identified during the previous EQR. •Page 91 of the *Provider Manual* also sounds as if all grievances are acknowledged in writing—it states BlueChoice will send a written acknowledgement of the grievance to the member within five calendar days from the date BlueChoice receives the grievance. *Quality Improvement Plan: Clarify the Member Handbook, page 63, and the Provider Manual, page 91, to indicate verbal grievances that can be resolved within 1 business day are acknowledged verbally and all other grievances are acknowledged in writing within 5 calendar days of the receipt date.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				As stated in Policy SC_GAXX_015, Grievance Process: Members, the *Member Handbook*, and the *Provider Manual*, BlueChoice follows a timeframe of 30 calendar days from receipt for grievance resolution. The *Grievance Acknowledgement Letter* and the *Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid* letter attachment state grievances are resolved within 90 calendar days from the date of receipt. *Quality Improvement Plan: Correct the grievance resolution timeframe in the Grievance Acknowledgement Letter and the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" letter attachment.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.		X				The *SCDHHS Contract, Section 19.35.3*, requires retention of grievance records for a period of no less than 10 years. During onsite discussion, CCME determined that records are retained for a minimum of 7 years but usually 10 or more years, and electronic records are retained indefinitely. However, page 8 of Policy SC_GAXX_015, Grievance Process: Members, is not consistent with the timeframes reported during this onsite discussion, and references both three-year and five-year timeframes for record retention. The policy also says, "Electronic files are maintained for longer than 5 years." This is vague and does not clearly convey the timeframe for retention of electronic records. *Quality Improvement Plan: To comply with requirements of the SCDHHS Contract, Section 19.35.3, revise Policy SC_GAXX_015, Grievance Process: Members, to reflect a record retention timeframe of at least 10 years. Ensure BlueChoice, Amerigroup, and any applicable delegated entities comply with this record retention timeframe.*
2. The MCO applies the grievance policy and procedure as formulated.		X				Review of grievance files reflect timely review and notification of resolution. Issues noted by CCME in the files include:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•One acknowledgement letter was not sent within the required timeframe. •One resolution letter does not address all findings of the investigation and can be misinterpreted by the reader. •One file does not contain evidence of the investigation of the grievance. Three files should have been referred for investigation as potential quality issues due to the nature of the allegations made in the grievance. Health plan staff reviewed the files during and after the onsite and concurred that these grievances should have been referred for investigation as potential quality incidents. *Quality Improvement Plan: Define and implement processes to ensure staff recognize and appropriately refer grievances that contain potential quality incidents for investigation.* *Recommendation: Ensure acknowledgement letters are sent within the required timeframe, that resolution letters include all appropriate information, and that files contain evidence of the investigation of the grievance.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					As stated in Policy SC_GAXX_015, Grievance Process: Members, quarterly reports of member grievances are presented to the Service Quality Improvement Committee (SQIC). The SQIC reviews the grievances to identify and address trends. Review of SQIC minutes confirms grievance data is reported quarterly and the data is discussed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					BlueChoice provided the *2018 Medicaid Quality Management Program Description* as evidence for the program the Plan has designed to provide the structure and key processes for ongoing improvements of care and services BlueChoice provides to members and providers. Similar discrepancies were found in the 2018 program description that were noted in the 2017 program description reviewed last year regarding the frequency for policy review. Page 24, under Policies and Procedures Supporting QAPI Programs, indicates that policies and procedures and other materials are reviewed annually and revised when indicated. However, on page 34, under Policies & Procedures, it states policies; procedures are reviewed, at a minimum, bi-annually. Onsite discussion confirmed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the polices are reviewed at least annually. Also, throughout the program description there is confusion regarding the name BlueChoice uses for their Quality program. For example, on page four the program is listed as Quality Assessment and Performance Improvement Program. On page five the program is listed as Quality Management Program. *Recommendation: Correct the following in the 2018 Medicaid Quality Management Program Description:* *•the frequency the policies and procedures are reviewed and* *•correct the program name throughout the document.*
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.		X				The QI Program Description, page 30 discusses the adoption of the clinical and preventive health guidelines; however, it does not mention monitoring provider compliance. Policy SC_QMXX_048, Clinical Practice Guidelines – Review, Adoption, and Distribution and policy SC_PCXX_006, Preventive Health Guidelines – Review, Adoption, Distribution, and Performance Monitoring discusses performance monitoring thru medical record audits. The policies are not clear about what is monitored. Also, the medical record audit tools do not include monitoring the Clinical Practice Guidelines. *Quality Improvement Plan: Update policy SC_QMXX_048, Clinical Practice Guidelines - Review, Adoption, and Distribution and policy SC_PCXX_06, Preventive Health Guidelines - Review, Adoption, Distribution and Performance Monitoring to include the monitoring process conducted to monitor*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider compliance with the clinical and preventive health guidelines. If medical record review will be used for monitoring, update the medical record data collection tools to include the monitoring of the guidelines.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Policy SC_UMXX_061, Under-and Over-Utilization of Services – Monitoring addresses the process BlueChoice uses to monitor utilization data.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) continue to have authority and accountability for the development and implementation of the QI program. Both committees report directly to BlueChoice's Managed Care Oversight Committee and the oversight committee reports to the Board of Directors.
2. The composition of the QI Committee reflects the membership required by the contract.	X					According to the committee membership list, Dr. Lloyd Kapp chairs the CQIC. The committee minutes do not reflect this. Voting members include 10 network providers and the Amerigroup Medical Director. A quorum of at least

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						three external physicians is needed to make decisions. Membership for the SQIC include the health plan's senior leaders, department directors, managers, and other staff. The identity of the chairman for this committee is not clear. The QI Program Description, page 9, indicates the Director of Quality chairs this committee. Page 16 indicates the committee is co-chaired by the Senior Manager of Corporate Quality & Accreditation and the Director of Member Services. The minutes do not reflect who chairs the committee. The Director of Member Services did not attend any meetings based on the meeting minutes reviewed with the desk materials. The Senior Manager of Corporate Quality & Accreditation and the Director of Quality only attended one meeting. According to the QI Program Description, page 12, the committee chair does not vote except in the instance of a tie. The *Committee Membership List* does not indicate who the chairs the committee and every member is listed as a voting member. *Recommendation: Indicate on each committee's minutes who is chairing the committee. Also, correct the discrepancy in the QI Program Description regarding who chairs the SQIC.*
3. The QI Committee meets at regular quarterly intervals.	X					The CQIC and the SQIC meet quarterly. A review of the committee minutes demonstrated that both committees met the meeting frequency requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					BlueChoice uses Inovalon, a certified software organization, for calculation of HEDIS rates. The comparison from the previous to the current year reveal strong increases in MMR, Flu vaccinations, Lead Screening in Children, and Adolescent Well Care visits, among a few other measures. The measures that decreased are Statin Adherence and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia among a few others. Details of the validation of the performance measures may be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects- one clinical and one non-clinical. The clinical project is titled "Childhood Immunizations Combo 3 and Lead Screening." The non-clinical project is titled, "Access and Availability of Care."
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Both projects received a validation score within the Confidence in Reported Results range. The projects documentation did not have evidence of new interventions being planned to address the lack of improvement in rates and the issues with the benchmark and baseline goal identified during the previous EQR were not corrected. Details of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						validation of the PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Quality Improvement Plan: Correct the errors identified in the performance improvement projects.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Included in the provider contracts. Also, BluceChoice includes information regarding provider participation in the health plan's QI activities in the *Provider Manual*, and on the health plan's website.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					BlueChoice produces a provider level *Gaps in Care Report* that identifies members that are experiencing a gap in care or a missed preventive service.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Amerigroup Partnership Plan is contracted by BlueChoice to provide administrative services for the Medicaid Managed Care product for members in South Carolina. The *Utilization Management (UM) Program Description* outlines the purpose, goals, objectives, and staff roles which include physical and behavioral health (BH). The *UM Program Description* was approved by the Clinical Quality Improvement Committee (CQIC) on April 18, 2018. Additionally, the UM Program coordinates with Amerigroup Pharmacy Services where pharmacy benefits and services are managed.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					The *UM Program Description* describes the UM Program's structure and methodology used to evaluate medical necessity.
1.2 lines of responsibility and accountability;	X					The *UM Program Description* describes lines of responsibility and accountability, indicating the Vice President of Health Care Management provides oversight of the UM Program at the corporate level and Amerigroup's Medical Director and Behavioral Health Medical Director have oversight at the contractor level.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines/standards used in making UM decisions are described in the *UM Program Description* and detailed in Policy SC-UMXX-118, Utilization Management Decision and Screening Criteria.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for timely UM decisions are described in the *UM Program Description*, *Pharmacy Program Description*, *Member Handbook*, and *Provider Manual*. Requirements are also noted on page 111 in Policy A16, Health Plan Pharmacy Benefits, and detailed in Policy SC-UMXX-117, Decision and Notification Timeframes.
1.5 consideration of new technology;	X					Consideration of new technology is addressed in the *UM Program Description*. The process for assessing appropriate use of new technologies, procedures, drugs, equipment and devices are addressed through the Office of Medical Policy & Technology Assessment Committee (MPTAC).
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Blue Choice does not provide additional compensation or incentive to providers or staff for denial of coverage or services as described in the *UM Program Description*, *Provider Manual*, and *Member Handbook*. Page 5 of Policy UMXX-065, Separation of Financial and Medical Necessity Decision-Making, states, "The Company does not specifically reward practitioners or other individuals for issuing denials of coverage." During onsite discussion, BlueChoice confirmed the company does not reward practitioners for issuing denials of coverage, specifically or otherwise, and will consider removing the word "specifically" from the policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the statement on page five of Policy UMXX-065, Separation of Financial and Medical Necessity Decision-Making, that "The Company does not specifically reward practitioners or other individuals for issuing denials of coverage."
1.7 the mechanism to provide for a preferred provider program.	X					The Preferred Provider Program began in December 2016 and is described in the *UM Program Description* and the *Preferred Provider Program Description*. Criteria for eligibility applies only to ear, nose and throat (ENT), pain management, gastroenterology, and orthopedic provider types who achieved a 94% approval on specific procedure codes. Onsite discussions revealed BlueChoice reviewed 2017 results and identified providers are not meeting the eligibility criteria. BlueChoice will consider adjusting program requirements to give providers the opportunity to meet criteria and to participate in the program. Review of desk materials did not identify how the Preferred Program was communicated to providers. BlueChoice confirmed the program is not communicated in the *Provider Manual*. *Recommendation: Include a description of the Preferred Provider Program in the Provider Manual and other provider resources as appropriate.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description* notes the Amerigroup Medical Director is responsible for supervision, oversight, and evaluation of the UM Program for medical and behavioral health at the plan level. The Amerigroup Medicaid Medical Director, Imtiaz Khan, MD is responsible for oversight of UM activities and he chairs the Quality Improvement Committee, where UM activities are reviewed and approved. This is reflected in 2018 CQIC meeting minutes and *the 2017 UM-CM Program Evaluation*.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					Annually, Amerigroup evaluates and updates the UM Program for medical and behavioral health services. Page 6 of the *2017 UM-CM Program Evaluation* states, "The UM work plan is reviewed annually and approved to maintain its relevance and accuracy. The work plan was recommended for approval to the Clinical Quality Improvement Committee (CQIC) as part of the QI work plan". The 2018 Quality Management work plan was reviewed and evaluated on April 18, 2018 by the CQIC and approved by the Amerigroup Medical Director. The Quality Management 2018 Work Plan was approved by SQIC on February 23, 2018. The MPTAC is a multidisciplinary group that is responsible for evaluating clinical standards and other decision-making guidelines for medical necessity criteria annually.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy UMXX-118, Utilization Management Decision and Screening Criteria, lists how utilization management standards and criteria are used for determining medical necessity. The screening criteria are evidenced-based and follow nationally recognized UM standards. BlueChoice primarily uses the following guidelines: federal and state mandates, member benefits, Amerigroup medical policy and clinical guidelines, MCG™ Guidelines, Amerigroup policy and procedures, Amerigroup behavioral health medical necessity criteria, and AIM Specialty Health Guidelines.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Sampled UM approval files reflect consistent decision making using criteria and relevant medical information as described in Policy SC-UMXX-041, Pre-service Authorization of Services.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies. The criteria for utilization is communicated in the *Member Handbook* and the *Provider Manual*. The applicable forms for abortion, sterilization, and hysterectomy services are correctly noted in the *Provider Manual*.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					BlueChoice allows for unique patient decisions in utilization management as noted in Policy SC-UMXX-118, Utilization Management Decision and Screening Criteria, which describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Page four of the *UM Program Description* states,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						"When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode- specific variables."
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					BlueChoice implements several methods to ensure UM standards/criteria are consistently applied to all members across all reviewers. The *UM Program Description* explains inter-rater reliability (IRR) is conducted annually to evaluate adherence to and consistent application of approved criteria and guidelines for physicians, non-physicians, licensed clinical staff, and behavioral health staff. Results are reported to designated corporate senior leaders and to the corporate Quality Improvement Committee and Medical Operations Committee. The Performance Improvement and Enhancement (PIE) Team conducts monthly associate-level clinical audits to assess compliance with NCQA guidelines and corporate policies and procedures. It is an independent Clinical Auditing Program reviewing components UM areas for Medical Directors and licensed physical and behavioral health clinical staff. Detailed monthly audit results are reported to the Health Plan Directors, Managers, Corporate UM teams, Quality Committees, Clinical and Senior Leadership. Policy SC-UMXX-050, Non-Physician Process and Focused Review Audits, describes how the Quality Review Program evaluates consistency of medical necessity determinations for Medical Review, UM, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Case Management (CM) nursing staff. Process audits and clinical reviews are conducted quarterly and have a benchmark of 95%. Policy SC-UMXX-120, Nurse Inter-Rater, notes an annual assessment is conducted by the Nurse Inter-Rater Committee for all non-physician licensed clinical staff making medical necessity determinations. The benchmark score is 90% and remediation is done for those who do not achieve it. Results are reported to the SQIC and CQIC committees. Policy SC-UMXX-078, Physician Inter-rater Reliability Assessment, notes that IRR for all physicians making medical necessity determinations is conducted annually. Remediation is done for physicians who do not achieve the minimum score of 80%. Results are reported to the SQIC and CQIC committees. During the onsite, BlueChoice explained the physician's benchmarks are established by corporate and are intentionally lower than the benchmark for nurses. Additionally, onsite discussions revealed the Pharmacy Department has an IRR process and the policy was provided for review. Policy A31, Pharmacy Inter-Rater Reliability Assessments, defines and describes the IRR process for pharmacy staff. The pharmacy IRR committee will remediate staff who do not achieve the 80% benchmark.
6. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the *Preferred Drug List*, including which over-the-counter (OTC) medications are covered with a prescription and those requiring prior authorization. Pharmacy benefit information is available in the *Member Handbook* and *Provider Manual*, and the PDL is posted on the BlueChoice website. The *Pharmacy Program Description* outlines the pharmacy services program and describes lines of responsibility. The Pharmacy and Therapeutics (P&T) Committee is made up of two interdependent subcommittees, the Clinical Review Committee and the Value Assessment Committee, that maintain the PDL. The *Pharmacy Program Description* notes Express Scripts, Inc. is the Pharmacy Benefit Manager for BlueChoice and can be contacted for benefit questions, including eligibility, PDL status, and benefit exclusions or inclusions.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Blue Choice has a process in place for making exceptions to the closed formulary based on medical necessity. The *Pharmacy Program Description*, *Member Handbook*, *Provider Manual*, and Policy SC-PMXX-005, Provisional Drug Supply Management, describe the process for members to be provided a five-day supply of medication in emergent situations while a prior authorization is pending. Policy SC-PMXX-025, Medicaid Pharmacy Lock-In Program, includes the requirement that members in the program can have a five-day medication supply

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provided by a pharmacy other than their designated lock-in pharmacy. Page 27 in the *Provider Manual* describes the Rx Safe Choice Program which has the same criteria has the Pharmacy Lock-In Program. On site discussion confirmed the program are named differently but are the same. The allowance for members to obtain specialty medication from a local pharmacy in specific circumstances is not communicated in any policy, the *Pharmacy Program Description*, or *Provider Manual*. The *Member Handbook* contains no information regarding specialty pharmaceuticals. *Recommendation: Use the same name for the Lock-In Program in Policy SC-PMXX-025, Medicaid Pharmacy Lock-In Program, the Provider Manual, and applicable documents. Revise an applicable pharmacy policy, Provider Manual, and Program Description to address the process for allowing members to obtain specialty pharmaceutical medication from a local pharmacy in clinically urgent situations. Refer to the SCDHHS Contract, Section 4.2.21.4. Include information regarding specialty pharmaceuticals in the Member Handbook, including the availability to obtain specialty medication from a local pharmacy in specific circumstances.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC-UMXX-01, 24-hour Access to Emergency Department Services, appropriately defines an emergency and addresses coverage for post-stabilization services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *Provider Manual* and the *Member Handbook* adequately describe emergency medical services and post-stabilization services and requirements.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Policies SC-UMXX-041, Pre-service Authorization of Services, SC-UMXX-013, Non-Authorization of Medical Services, the *Pharmacy Program Description*, and the *UM Program Description* describe staff who are licensed and trained to perform clinical reviews. Additionally, they indicate professionals who can render denials and review cases which the UM staff cannot approve. The *Pharmacy Program Description* explains that precertification requests are processed using a web-based application and requests that do not meet criteria are forwarded to a clinical pharmacist for review.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization requests for UM approval files were consistent with Policy SC-UMXX-041, Pre-service Authorization of Services, and *SCDHHS Contract* requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Sampled denial files reflect decisions are made by appropriate physician specialists as outlined in Policy SC-UMXX-013, Non-Authorization of Medical Services.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Denial decisions are made according to the processes described in Policy SC-UMXX-041, Pre-service Authorization of Services, and Policy SC-UMXX-117, Decision and Notification Timeframes. *Notice of Adverse Benefit Determination* letters to the provider and member indicate the criteria used for decision-making, give clear explanations that are easily understandable, and include clear instructions for the appeal process.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					The *UM Program Description*, Policy SC-GAXX-053, Provider Appeals, and Policy SC-GAXX-051, Member Appeal Process, outline the appeals processes for providers and members. The *Provider Manual* and *Member Handbook* provide circumstances and instructions for the appeal process.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;		X				Instructions for filing an appeal are listed in the *Member Handbook*, *Provider Manual*, Policy SC_GAXX_051, Member Appeal Process, and adverse benefit determination notices. The reader is instructed to mail the Member Appeal Request Form to BlueChoice; however, the receiving department is listed differently in the following documents:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The *Member Handbook*, page 65, says to address it to the "Appeals Coordinator" •The *Provider Manual*, page 90, says to addresses it to the "Attn: Grievance and Appeals" •The *Member Appeals Request Form* says to address it to "Attn: Grievance Department" •In two separate areas the adverse benefit determination notice says to mail it to the "Grievance and Appeals Dept." and "Attn: Appeals Coordinator" The *Member Appeals Request Form* is accessible from the BlueChoice website. The *Provider Manual* has a hyperlink on page 90 that opens directly to the BlueChoice website and it gives step-by-step instructions on how to access it from the website. The *Member Handbook* does not have the hyperlink to access the form or the step-by-step instructions. Onsite discussions revealed the change to the *Member Handbook* was recently made. BlueChoice allows 60 calendar days from the date on the adverse benefit determination notice to file an appeal, as state on page 4 of Policy SC-GAXX-051, Member Appeal Process. Page three and page six of the adverse benefit determination notice indicate an appeal should be requested within 90 calendar days. Additionally, page 55 of the *Member Handbook* references the timeframe to request an appeal is within 90 calendar days. *Quality Improvement Plan: Correct the timeframe to file an appeal in the adverse benefit determination notice and the Member Handbook.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit the mailing addresses in the Member Handbook, Provider Manual, the Member Appeal Request Form, and the Notice of Adverse Benefit Determination letter to have consistent language for the receiving department.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					The process for expedited appeals is described in Policies SC-GAXX-051, Member Appeal Process, the *Member Handbook*, and the *Provider Manual*.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt as documented in Policy SC-GAXX-051, Member Appeal Process, the *Member Handbook*, and the *Provider Manual*. Onsite discussion confirmed the appeals timeline for extensions begins with the receipt of the initial notification, either verbally or written. The following issues related to extensions of appeal resolution timeframes are noted: •Policy-SCGAXX-051 Member Appeals Process, page eight, sections M and O, and the *Member Handbook* do not address the *SCDHHS Contract, Section 9.1.6.1.5.1* requirement to make reasonable efforts

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to give the enrollee prompt oral notice of the delay and the *SCDHHS Contract, Section 9.1.6.1.5.2* requirement to give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision within 2 calendar days." •The *Member Handbook*, page 66, also does not address the *SCDHHS Contract, Section 9.1.6.1.5.3* requirement that the health plan must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. *Quality Improvement Plan: Include all requirements applicable to contractor-initiated extensions of appeal resolution timeframes in Policy SC-GAXX-051, Member Appeals Process, and the Member Handbook. include.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC-GAXX-051, Member Appeals, indicates performance of State Fair Hearing requests and member appeals are monitored and reported to the SQIC to identify and address trends. Member appeals are consistently reported on a quarterly basis as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified in SQIC minutes. Onsite discussion confirmed there are no State Fair Hearings to report. The files reviewed for member appeals identified Appeal Request Forms or Appeal Representative Forms were not consistently included in the records. Onsite discussion revealed BlueChoice makes attempts and follows policy guidelines to obtain the forms but will not discontinue the appeals process if the member or provider does not submit a request form.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The *Case Management (CM) Program Description* outlines the program goals, objectives, lines of responsibility, and operations. Several policies are in place to ensure comprehensive coordinated care for members, such as SC-CAXX-007, Care Management Targeting / Case Finding, SC-CAXX-106, Case Management Documentation, and SC-CAXX-108, Targeted Case Management - Identification and Referral of Eligible Members. The CM Program is communicated in the *Member Handbook* and the *Provider Manual*. Review of desk materials does not identify how BlueChoice meets the *SCDHHS Contract, Section 5.1.1* requirement to conduct an initial screening of each enrollee's needs within 90 days of the effective date

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of enrollment. Onsite discussion revealed this requirement is fulfilled by a vendor, Eliza. *Recommendation: Address in an appropriate policy or other document how the requirement to conduct an initial screening of member needs for all new members is met.*
2. The MCO has processes to identify members who may benefit from case management.	X					Policy GBD-CM-019, Case Management Program Case Identification, the *CM Program Description*, and the *Provider Manual* describe the various methods for eligible members to be referred into case management, such as data mining activities, referral from providers, or internal referrals.
3. The MCO provides care management activities based on the member's risk stratification.	X					BlueChoice provides care management activities based on the member's risk stratification as described in Policy GBD-CM 022, Case Management Caseload and Complexity Guidelines. Qualified Case Managers and other staff service members in the appropriate risk levels as noted in the *UM Program Description* under "Qualifications of Clinical Case Management Associates."
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					BlueChoice utilizes care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to the *Standards of Practice for Case Management*. Additionally, services are provided to members eligible for targeted case management as outlined in Policy SC-CAXX-108, Targeted Case Management - Identification and Referral of Eligible Members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					
5.2 The MCO has a designated Transition Coordinator who meets contract requirements			X			CCME is unable to identify how BlueChoice meets the requirement to have a designated Transition Coordinator. *Quality Improvement Project: Designate a Transition Coordinator to fulfill the requirement indicated in the SCDHHS Contract, Section, 5.6.2.*
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The UM Program Evaluation and Policy GBD-CM-028, Case Management Satisfaction Survey, describes the purpose and process to measure case management performance and member satisfaction. The information obtained from the surveys is used to evaluate and improve the CM Program. The QIC evaluates results of the CM Program and reviews quality and aggregate data from member satisfaction survey reports and complaints. Star Manly presented the 3rd quarter CM Member Satisfaction Survey results to the SQIC on February 23, 2018 and reported 94% of members enrolled are satisfied with the overall program. This is above the established benchmark of 90%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate care management activities are conducted as required and Case Managers follow policies to conduct the appropriate level of case management.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					BlueChoice monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization which may impact health care services, coordination of care, and appropriate use of services and resources according to Policy SC-UMXX-061, Under- and Over-Utilization of Services - Monitoring.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					BlueChoice analyzes and monitors data for utilization services. Results are reported at committee meetings and were included in the *2017 UM-CM Program Evaluation* and *2017 UM-CM Under and Over Utilization* report.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all subcontractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Policy HP 003-12, Oversight of Delegated Activities, outlines the procedure for oversight of all delegated activities. All delegated organizations have a written, signed agreement designating the delegated activities with the compliance and oversight requirements included. BlueChoice has delegation agreements with the following: • Greenville Hospital System, Roper St. Francis, Physicians Network, VSP, Medical University of South Carolina, Department of Mental Health, Palmetto Health USC Medical Group, AnMed Health for Credentialing/Recredentialing. • Anthem for various Medical Review Services, Federal External Reviews, Special Investigations Unit (SIU) Reviews. • Express Scripts, Inc. (ESI) for Pharmacy Services.
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Policy HP 003-12, Oversight of Delegated Activities, states that oversight of a delegated organization occurs at least annually and includes a review of compliance with accreditation standards, contractual requirements and written policies and procedures and any incentive structure in place. Policy MCD-10, Credentialing Delegation, defines the process for delegated credentialing activities which includes a pre-delegation audit for proposed delegates and annual oversight for entities where

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						credentialing has been delegated. The delegates must meet both BlueChoice HealthPlan Medicaid and SCDHHS credentialing standards. Evidence of annual oversight conducted within the last year was provided for all delegated entities. The oversight reports and tools are comprehensive. However, Policy MCD-10 does not address the SSDMF as a query item even though it was addressed in the delegation oversight tool. In addition, for delegated credentialing, the Terminated for Cause List needs to be added to the delegation oversight tool, Credentialing Requirements for Vendor document, and the policy as a query item. *Quality Improvement Plan: Update Policy MCD-10, Credentialing Delegation, to include the SSDMF as a query item and add the Termination for Cause List as a query item to the policy, Credentialing Requirements for Vendor document, and the delegation oversight tool.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V II. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Per Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, BlueChoice encourages providers to follow the recommendations of the Centers for Disease Control (CDC) and to use the American Academy of Pediatrics Bright Futures tool kits which include the EPSDT guidelines. Network providers are informed of the EPSDT program and immunizations schedule through the Provider Manual, Provider Bulletins, and other communications. Quarterly Gaps in Care reports are disseminated to providers by Provider Network Services staff and/or the Quality Management Department. Provider compliance with administering required immunizations is monitored through random medical record reviews conducted by nurse reviewers. Providers must report immunization data to the SCDHEC's State Immunization Information System (SIIS).
1.2 performing EPSDTs/Well Child Visits.	X					Provider compliance with providing EPSDT services is monitored through medical record reviews conducted by nurse reviewers. A signed refusal statement must be placed in the medical record as evidence of voluntary refusal of an assessment/service by the member/responsible party.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Deficiencies from the previous EQR which have not been addressed include: •Discrepancies were noted in the Compliance Committee's membership across the Compliance Committee Charter, the QI Program Description, and the Committee Membership List for the Medicaid Compliance Committee. •The Member Handbook, page 63, continues to indicate all grievances are acknowledged in writing, which differs from the actual process for verbal grievance acknowledgement for certain grievances. *Quality Improvement Plan: Ensure all deficiencies identified in the EQR are addressed and the corrections are implemented.*